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An Epidemic of Meningitis[1]

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SINCE our city was not fortunate enough to have a hospital for communicable diseases at the time of the epidemic, the general hospitals were called upon to open their doors. At the Saginaw General Hospital, the largest wing on the medical floor was utilized for this purpose. This ordinarily accommodates eighteen patients, but during the epidemic as many as thirty-three were placed there, the majority being children.

Nursing care was a very important factor. We were authorized by the county authorities to engage as many graduate nurses as seemed necessary to give the patients the best of care. The nurses were selected from the local registry and from registries located in various cities of the state. The hours of duty were eight, and the number of patients per nurse averaged from three to four.

These nurses were given a ward in the old hospital for a dormitory, with rooms for dressing rooms and living rooms. A member of the Board of Trustees provided several rooms in her own home for night nurses. The largest number of nurses were on duty between the hours of seven a.m. and three p.m., as the majority of spinal punctures were done at that time.

Besides the general nursing care, special emphasis was placed on watching for unfavorable symptoms following the administration of the serum. Two nurses were usually required to assist in serum administration and one nurse was always left with the patient for a short time afterward to guard against any reaction. This was considered a very important matter in view of the frequency with which reactions followed serum administration by spinous, occasionally muscular, but particularly by the venous route.

Routine isolation precautions in regard to dishes, linen, the wearing of masks and gowns, were carried out. None of those caring for the disease developed it.

Treatment

IN this article we shall hold to facts gained from the observation of a series of 102 cases over a period of three months and shall deal solely with treatment, since a description of symptoms and diagnosis is covered well in any standard textbook on medicine. We shall deal with cases as found in the epidemic form which, it is generally agreed, are more severe as

[1] See also the report on the follow-up on 315 cases, by Dr. Rockwell M. Kempton, in the current *Public Health Nurse*.

regards both symptoms and complications than are sporadic cases.

It would be well to state at the outset that, particularly in the presence of an epidemic, a safe rule to follow would be to treat as a true meningitis any suspicious case, in view of the importance of giving serum early. Practically all the ways and means mentioned in textbooks on the subject were given a trial over the series of cases we dealt with, and those which appeared to give the best results came to be the nearest approach to a routine treatment adopted. By far the most important therapeutic agent was anti-meningococcic serum, and we will describe rather fully the various modes of administering the serum and the results as we found them in the various methods. One or two case histories will be given, in brief, to illustrate routine serum treatment and deviation from the same as circumstances seemed to warrant.

It cannot be too strongly stressed that serum therapy, to be effective, must be given early. Eighty per cent of deaths occurred during the first week in hospital and 70 per cent died within three days. This 70 per cent represents almost entirely cases in which early diagnosis and early serum administration were not obtained.

At the beginning of the epidemic, following the treatment advised in texts on the subject, we started giving serum by spinous, venous and muscular routes, repeating these doses every twelve to eighteen hours, as long as the patient failed to show improvement. It was observed that these cases did not do any better or even as well as a number in which the serum was not pushed so vigorously, and in many of the former cases there was an unfavorable reaction to so much serum. The body seemed to have a saturation point beyond which serum retarded rather than aided the process of recovery. For this reason the serum was discontinued, except in a very few cases, by the venous route, and was used less frequently by spinous and muscular routes, and the results were just as good or better.

Intraspinal Administration of Serum

BEARING in mind the importance of giving the body all it could assimilate in the first few hours and of reaching the "saturation point" quickly, serum was given, in the average case, every twelve hours for the first two or three doses, depending on the case. Thereafter it was given every twenty-four hours for two to four doses in a case making good recovery, and was continued for as many doses as seemed necessary in the stubborn case. After initial twelve-hour doses it did not seem necessary to give serum oftener than every twenty-four hours.

At first, being on the watch for a lighting up of infection after the patient was on the way to recovery and the serum had been discontinued, we were misled by cases in which, seven to nine days after serum had been discontinued, the patient would show a rise in temperature, headache, restlessness and often a rash—simulating to some extent the symptoms at the onset of the disease. A spinal puncture, in a majority of instances, showed the spinal fluid to be clear but under considerable pressure. Since it stood to reason that it would take some time for intraspinous pressure to return to normal, even after the disappearance of marked symptoms, we came to regard these cases as due to a delayed serum reaction. In these cases the best results were obtained when a small amount of fluid was drained away (10 to 20 cc.) and

no serum given, or at best a half ampule or 7.5 cc.

No attempt was made in these cases to reduce the pressure to normal, as it seemed reasonable to suppose that nature had an object in providing an excess of fluid to keep the inflamed membranes apart as she does in pleurisy and pericarditis. If, after withdrawal of fluid, the symptoms were unrelieved or progressive, routine treatment was resorted to, on the grounds that it was a lighting up of the original infection. By this treatment patients showed a more rapid improvement than where resort was made to large doses of serum on the first appearance of symptoms suggestive of an aggravation of the meningitis.

In giving serum it is best raised to body temperature before injection. This was accomplished by dropping the vials into a basin of water at body temperature and then rinsing them in a basin of alcohol immediately before use. We found that a dressing cart laid out as a table was a great convenience in giving treatment as it could be wheeled rapidly from room to room and all the necessary instruments, etc., were always at hand. A few extra needles were kept in a basin of alcohol on this cart, to be used with odd vials of serum, as only one needle came with each package of two vials and often only one vial was used.

Puncture was done in the usual manner, the skin being sterilized with iodin followed by alcohol and a dressing of collodion used afterwards. After doing several punctures at one site, difficulty was experienced in getting into the canal on subsequent attempts. This was attributed to an exudate around the traumatized area and, by moving up one or two intravertebral spaces, entry was gained without difficulty.

The amount of spinal fluid withdrawn varied from 20 to 50 or even 60 cc., depending on the size of the individual and the amount of pressure. In routine treatment we considered enough fluid had been withdrawn when it began to drip rather than run out. In withdrawing fluid too rapidly or too completely there is danger of the medulla herniating down into the foramen magnum and causing respiratory failure from pressure on the medulla.

Venous Administration of Serum

WE used this on practically every case at the beginning of the epidemic. However, the danger of anaphylaxis in intravenous serum administration is very grave. (We lost two cases by anaphylactic shock and had severe shock in several other cases.) We discarded intravenous therapy entirely in the later period of the epidemic, as the value of it by this method seemed to be so greatly offset by the danger of anaphylactic shock. If venous administration is used, one should be prepared beforehand to combat anaphylactic reaction and snould have ready hypodermics of adrenalin, of caffein sodium benzoate, and of lobelin, which latter is of great value in respiratory failure, in doses of one-half to one ampule.

Muscular Administration of Serum

THIS method has as definite value as has the use of antitetanic serum and antidiphtheritic serum and acts as a reservoir in the muscles from which serum is slowly absorbed into the system. It may be given up to 50 cc. into muscles of the back or preferably the buttocks. Where the large dose is given, it is well to distribute the amount at several points.

In giving serum intraspinally, how much should one give? We aimed to give roughly one-half to three-fourths the amount of spinal fluid withdrawn. That is, if 45 to 50 cc. of spinal fluid were withdrawn, we gave 30 cc. In the case of children, 25 to 30 cc. of fluid withdrawn warranted the injection of a 15 cc. ampule, the aim being to relieve the pressure as well as to give the serum.

Serum Given into Cisterna Magna

THIS method of administration, as we came to believe, had a definite indication and is of proved value, as illustrated by a case below. It will be seen by a perusal of this case that all the recognized methods of combating convulsions were tried before resorting to puncture of the cisterna magna, and its immediate beneficial effect was conclusive evidence that it was of unmistakable value. In view of the added danger of giving serum in this way, it should not be resorted to in the absence of definite indications. Those indications are:

Inability to find a marked pressure in the spinal canal with marked cerebral symptoms, such as great restlessness, convulsions and progressive symptoms of toxemia, indicative of walling off of the cranial vault and spinal canal by exudate, probably in the region of the foramen magnum.

The Technic.—Shave the hair from the region of the occiput down to the hair line on the neck. Paint the area with iodin and follow with alcohol. Have the assistant hold the head in the erect position so that the spinal column and the skull are in one straight line. Enter the needle exactly in midline and midway between the promontory of the occiput and the atlas. Direct the needle toward a line through the supraorbital margin and enter the needle cautiously, removing the stylette frequently, and *stop* as soon as fluid is obtained.

Precautions and Dangers.—The needle must be in midline and the head held perfectly still, because of danger of injuring the vertebral arteries. The serum must be warm before being injected around the vital centres of medulla. Do not force the needle in further if fluid is not obtained as there is danger of penetrating the medulla and a respiratory death. Anesthesia is indispensable unless the patient is comatose. The amount of serum given here is the same as into the spinal canal and varies as the size of the individual and the amount of pressure encountered.

Some Miscellaneous Notes of Practical Value

IN two or three cases where examination of the fundi showed protruding of the nerve head and venous engorgement with disturbance of vision, simple puncture of the cord was carried out to relieve the intracranial pressure and, where this persisted over a period of several days with no other symptoms, to avoid the necessity of doing a puncture, large doses of magnesium sulphate by mouth and by retention enema showed some results; the idea here being the depletion of the body fluids generally.

In the convalescent stage, general tonics were used, avoiding those as much as possible which contained strychnin which would excite an already over irritable nervous system. The quartz lamp was used in those cases showing a tardy convalescence, the exposure being of the entire body, and this seemed to give some results in hastening the return of the patient's strength.

In two cases nasal feeding was resorted to where the patient was unable to coöperate sufficiently to

take nourishment in any other way. In one of these cases saline glucose was used by hypodermoclysis for several days, but this could not be continued indefinitely, as seemed necessary at the time, so the nasal tube was passed and a feeding containing two eggs, an ounce of sugar, and milk q.s. one pint, was given four times in the twenty-four hours. For the most part these feedings were well retained, and in one instance of the two mentioned I am quite convinced that they were a very important factor in the recovery, as improvement began shortly after the feedings were instituted and continued. The evidences of meningitis at the time had almost disappeared and the patient seemed to be sinking lower from day to day, with no direct cause apparent, and we had reached the point where we despaired of her recovery.

Narcotics were used fairly freely in the acute stage, as the suffering in a good many of the cases was severe.

Slight chloroform anesthesia was used in nearly all cases when doing punctures. It seemed warranted both from the standpoint of the suffering of the patient and because in many cases it was impossible to get the patient to coöperate, due to delirium or fright. It seemed to us that it did less damage to give a patient a little chloroform than to have him cavorting around the bed with a needle in his back, despite the efforts of three or four nurses, where one or two would otherwise suffice. In many cases their efforts served only to keep the patient on the bed, without keeping him in anything like the orthodox position for a spinal puncture.

In judging when a patient was ready to be discharged, we followed approximately, with variation in individual cases, the rule of six to seven days of normal temperature, general condition, the occurrence of a previous relapse, bearing in mind the liability of a patient to relapse even after five to six days apparently on the road to recovery. The presence of complicating conditions had to be taken into account, also. Last, but by no means least, was the negative throat culture. In two instances, only, were positive cultures returned on patients about to be discharged. In these cases the patients were made to gargle the throat with equal parts of hexylresorcinol and water. The nose and throat were sprayed with equal parts of hydrogen peroxid and water and the nose was packed with argyrol tampons. This was done t.i.d. In both cases cultures were taken again in two or three days and were returned negative.

Case Histories

Serum Administration into Cisterna Magna

Case I

THE child entered the hospital on Saturday, April 20, in deep coma and having almost continuous convulsive seizures. The previous Thursday she had complained of feeling sick, with some headache and abdominal pain, but these symptoms cleared up entirely, so far as could be learned from the father, and she did not have any more symptoms until Saturday, when the disease was ushered in with severe convulsive seizures. From this picture the onset of the disease probably dated back to Thursday.

Examination of the child revealed no marked head retraction, the eyes were rolled up under the lids, pulse was weak and irregular, and the limbs were in constant motion with a coarse tremor. Spinal puncture was done and 25 cc. of very cloudy fluid

under pressure were withdrawn. Fifteen cc. serum were given intraspinally and 15 cc. were given intramuscularly.

This was at 10.30 a.m. Condition at the time was noted as poor. Convulsions had not ceased at noon and the following treatment was given:

At 1.30 p. m., half an ampule of magnesium sulphate intravenously; 15 cc. of serum intravenously; half an ampule of calcium lactate intravenously.

At 2.15 the nurse's notes read: Patient resting more quietly, appears to be sleeping.

3. p.m.: Convulsions every few minutes again.

4.30 p.m.: Convulsions almost constant.

9 p.m.: 500 cc. saline by hypodermoclysis.

9.30 p.m.: Chloral hydrate per rectum.

10.45 p.m.: Convulsions not as often.

2 a.m.: Convulsions approximately every three to five minutes and lasting about three minutes.

Chloral per rectum repeated.

4.30: Condition not improved . . . about the same as before.

Sunday: Condition poor, convulsions frequent.

Progress notes *Sunday:* Convulsions persisted all day yesterday and during the night and this a.m.; at noon today a cisterna magna puncture was done, following which she had about four convulsions during the next thirty minutes, none after that apart from slight twitching at times.

Monday: Condition was much improved today, and she slept naturally most of the time; in the morning a spinal puncture, only, was done.

Tuesday: Temperature was up slightly and, on doing a spinal puncture, the fluid returned about the same color as the serum. This would seem to indicate that the spinal fluid was not circulating and that the fluid withdrawn was of the nature of the serum given yesterday. As soon as this became evident the spinal puncture was discontinued, little fluid being withdrawn and no serum given, and a cisterna puncture was done. Here a marked pressure was evident where it was very slight in the spinal canal, and the fluid was more purulent in appearance. This was, to our mind, evidence that there was a walling off of the cranial vault and the space around the cord. Serum was given into cisterna and improvement was noted shortly after.

After this, routine treatment was resorted to and the patient is now in a condition that warrants discharge, the only feature that is left is an internal strabismus.

Case II

THE patient, aged fourteen, was taken acutely ill suddenly, with headache, vomiting, pains in back, dizziness and mental confusion. Entered hospital three days after onset, marked head retraction, partial coma, vomiting, severe headache, marked Kernig's sign. Temperature 102°. Pulse 110. Spinal fluid loaded with pus cells and meningococci.

This patient's illness ran on for three months and during that time she was comatose a great part of the time.

Glucose saline was given by hypodermoclysis for a week, as she did not eat. Numerous abscesses developed over various parts of the body and a large one developed under the breast. Nasal feeding was resorted to.

She received serum as follows:

Day	Intramuscularly	Intraspinally	Intravenously	Cisterna Magna
1	50 cc.	30 cc. 25 cc.	45 cc.	
2	15 cc. 30 cc.	25 cc. 15 cc.		
3	20 cc. 30 cc.	15 cc. 30 cc.		
4	30 cc.	30 cc.		
5	30 cc.	30 cc.		
6		30 cc.		
7				30 cc.
8				
9	30 cc.	30 cc.		
10				30 cc.
11	30 cc.	30 cc.		
12				30 cc.
13		40 cc.		
14	30 cc.	45 cc.		
	None given	until 22nd day		
22		15 cc.		15 cc.

Extracts from Progress Notes:

4th day: Condition very poor and appears to be progressing rapidly to fatal issue.

7th day: Condition more grave, spinal fluid quite yellow, pressure not marked, small abscess below right breast, opened and drain inserted.

13th day: Not making any progress, is being fed nasally now, glucose saline by hypodermoclysis, outlook decidedly poor.

15th day: Condition about as before — transient improvement following injection of blood from a patient who was recovering.

18th day: Condition slightly better, but outlook on whole not encouraging; lies in a stupor or tosses in restless delirium.

25th day: Developing abscess on left hip.

30th day: Having quartz light treatment—some improvement noted.

33rd day: Having trouble retaining food and is vomiting food taken; sedative given and stomach washed before food is given.

43rd day: Still vomiting in the afternoon.

45th day: Vomiting not so severe, seems considerably improved.

57th day: Vomiting occasionally. First throat culture negative.

59th day: Abscesses of breast and buttocks still draining, patient very weak.

69th day: Condition about as before, abscesses still draining.

79th day: Condition steadily improving and outlook is good, is very weak.

89th day: Up in wheel chair, condition good —drainage almost ceased, almost ready for discharge.

Follow-up Report reads: Good recovery, no complications, and is attending school.

This was the case of longest duration that we took care of and presented a great many complications during her illness. For many days during the first part of the disease the case looked hopeless and she seemed to be about to die from general weakness rather than direct effects of meningitis, when resort was made to nasal feeding.

Cerebrospinal Fever

CEREBROSPINAL fever is an infection with the meningococcus (diplococcus intracellularis meningitidis, Weichselbaum). The essential lesions of the disease are chiefly focused upon the meninges of the brain and cord. The disease occurs both in localized epidemics and sporadically. . . .

Cerebrospinal meningitis is spread chiefly by carriers. The period of incubation is difficult to determine; it is stated to be from two to ten days, commonly seven. It may be one day in the young.

Epidemics of cerebrospinal fever are chiefly local and rarely widespread. . . . Children and young adults are most susceptible. Cerebrospinal fever is called a disease of children and soldiers. . . . Predisposing factors play an important rôle in depressing immunity and facilitating infection with the meningococcus. Over-exertion, long marches in the heat, depressing mental and bodily surroundings, catarrhal inflammations, the misery and squalor of tenement life, and the sad conditions of some mining and laboring camps have long been recognized as predisposing causes. . . .

Cerebrospinal fever is not highly communicable but spreads slowly and irregularly. . . . It is usually difficult to trace connection between one case and the next—its movement shows curious pranks. This is now explained through carriers. Except in sharply localized outbreaks, it is rare to have more than one or two cases in a home. . . .

The case fatality is usually high, about 75 per cent, occasionally being as low as 20 per cent in some epidemics. The use of serum has reduced the death rate to about 25 per cent.

The immunity produced by one attack is not lasting. . . .

It is probable that the meningococcus enters the system through the mucous membrane of the nasopharynx. From this position it may reach the meninges directly through the lymph channels, but usually indirectly through the circulation. . . .

A better knowledge of the facts concerning cerebrospinal fever has shaken our confidence in the practical value of preventive measures. Antimeningitis serum is useful in the treatment of the disease, it is not practical as a preventive. It must be introduced into the subdural space by lumbar puncture. Intravenous injections to counteract blood infections are also indicated. The serum should always be matched with the particular strain of meningococcus to obtain specific results.—Abstract from *Preventive Medicine and Hygiene*, by M. J. Rosenau, 4th ed., 1921, D. Appleton and Co., pp. 250–258.

The Prevention of Congenital Syphilis[1]

JAMES. R. McCORD, M.D.

IT is probable that in the future nurses will take a wider interest in the activities of public health work and preventive medicine than they are doing at the present time. Certainly their opportunities along these lines will be greater. The training schools are demanding more preliminary work and a better cultural foundation, and their teaching follows sound pedagogical principles. We shall presently see in the nursing field many more excellently trained women capable of solving the numerous health problems that will be theirs.

A concerted effort is being made over the world to improve the practice of obstetrics. It seems a tragedy that this specialty, above all others, should be so closely interwoven in the economic affairs of the people. There can be no short cut in good obstetrics. To obtain the best results for mother and baby, the way is long and laborious. Best results, as a rule, in our country cost money, and childbirth is not a monopoly of the well-to-do. The nurse of the future is going to play a very large part in the solving of the obstetric problem, particularly along prenatal and preventive lines.

I think it is generally conceded that syphilis, with its myriad manifestations and complications, is a menace to the health of the nation. I know of no reliable statistics of the incidence of congenital syphilis. Certainly it is frequent and, once present, it usually exacts from the child every hope for the future when life's journey is scarcely begun.

[1] This article was the basis of three talks made before the Southern Division of the American Nurses' Association and the Georgia and Mississippi State Associations by the author as the representative of the American Social Hygiene Association.

It seems quite likely that the congenital syphilitic, in every instance, contracts the disease from the mother. The external manifestations of syphilis in women are, as a rule, not nearly so marked as in men. As a general rule, the duration of the disease in the mother can be disregarded when speaking of congenital syphilis. If the mother has syphilis, early or late, the fetus will usually get the disease.

The sure cure for congenital syphilis is to prevent it. This can be done if the disease in pregnant women is recognized, and the earlier in pregnancy the better the chance for the unborn child. When Utopia is reached, every prospective mother will have a haven of perfect prenatal care; this will include an examination by a skilled syphilographer. Until then, the diagnosis of syphilis in pregnant women will, in the majority of cases, depend upon the positive blood Wassermann reaction. (A history of premature or full term stillbirths or deaths in very early infancy is a demand for thorough serologic study.)

The Wassermann test for syphilis is, at the present time, a complicated one. The opportunities for errors and false readings are almost multitudinous. To accept a report with confidence, the Wassermann should be done in a well equipped laboratory doing many of these tests, by an experienced serologist. Even then, a positive report, when possible, should be checked by another specimen of the blood.

It is probably best not to try to cure the syphilis of a woman during her pregnancy, being content to prevent the fetus from getting the disease. This prevention, if started early in pregnancy, the earlier the better,

certainly before the fifth month, is almost uniformly successful.

It is the custom in our clinic to give these women a weekly dose of .45 gram of neo-salvarsan and at the same time a mercurial inunction. The more ignorant the patient, the more careful one has to be not to inflict a continued pain. For this reason, mercury and bismuth are not used by hypodermic. I would repeat that we are trying to prevent syphilis in the baby, not to cure the disease in the mother at this time. These treatments are given each week until the baby arrives. The urine is examined for albumin and the blood pressure is taken before each treatment. I have not been able to determine that these treatments are injurious to pregnant women.

The thought is rather universal that the newborn baby with syphilis usually has external manifestations of the disease. This is far from being true. Some babies do have definite external signs of the disease. Their description is not in the scope of this article. The fact is, probably the majority of live syphilitic babies are born with no definite evidences of the disease, other than poor nutrition. Very often they are apparently well and healthy. If the Wassermann done on the cord blood, collected at the end of the second stage of labor, has been properly done and shows a strongly positive reaction, the baby, in my opinion, has syphilis. A negative cord Wassermann reaction does not mean that the baby has not syphilis. Probably fifty-six per cent of congenital syphilitics, in early infancy, have negative cord Wassermann reactions. Many of these babies develop a positive blood Wassermann in early life; the blood of perhaps an equal number remains persistently negative. Evidences of the disease may develop at any period from birth until early adult life.

It should be remembered that many congenital syphilitics are "apparently" cured by persistent and proper treatment, that every live baby born of a serum-positive woman is a potential syphilitic and should be constantly observed over a prolonged length of time so that the disease can be quickly detected and proper treatment instituted early.

Syphilis has no respect for race, color nor class; its incidence is high and its ultimate result, in almost every untreated case, a tragedy. Careful prenatal study and early persistent treatment can, in almost every instance, prevent congenital syphilis.

Results Obtained in Treating Syphilitic Pregnant Women[1]

THE histories of a group of 213 pregnant syphilitic women were studied before and after they had treatment.

Without treatment the pregnancies occurring resulted as shown in Diagram I on page 390.

Of the 26.46 per cent alive at three months, it is probable that at least one-half will die in the first five years, and many of those surviving infancy will show the stigmata of congenital syphilis. Only a few of them will be apparently normal. *With treatment* the pregnancies of the same women resulted as shown in Diagram II on page 390. Of the 91.87 per cent alive at three months, it is probable that all will be healthy, non-syphilitic children.

[1] Prepared and published by permission of the American Social Hygiene Association, 370 Seventh Avenue, New York, N. Y., May, 1929.

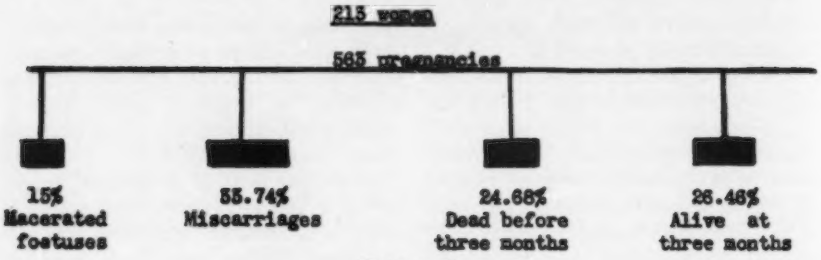


DIAGRAM I

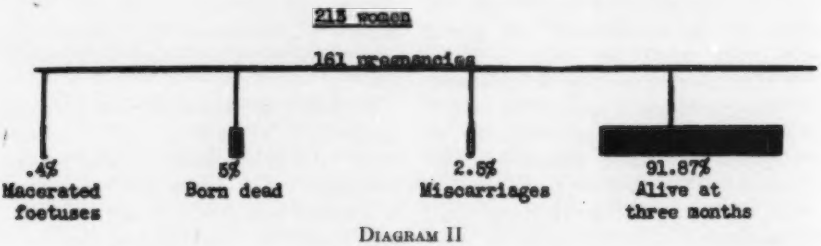
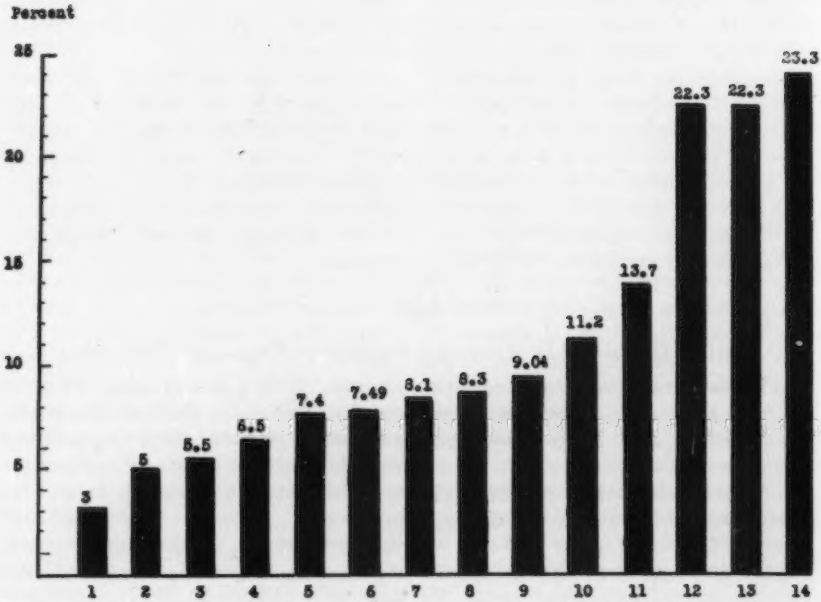


DIAGRAM II



Per cent of women with syphilis in prenatal clinics, based on 14 studies of a total of 58,000 unselected cases in 30 clinics

How to Evaluate Existing Nursing Procedures[1]

MARTHA RUTH SMITH, R.N.

"The real essence of nursing, as of any fine art, lies not in the mechanical details of execution, nor yet in the dexterity of the performer, but in the creative imagination, the sensitive spirit, and the intelligent understanding lying back of these technics and skills. Without these, nursing may become a highly skilled trade, but it cannot be a profession or a fine art. All the rituals and ceremonials which our modern worship of efficiency may devise, and all our elaborate scientific equipment will not save us if the intellectual and spiritual elements in our art are subordinated to the mechanical, and if the means come to be regarded as more important than the ends."—From an Editorial in the *Nursing Education Bulletin*, Volume II, Number 1, Teachers College, Columbia University.

THE actual evaluating of a nursing procedure and the *how* of reaching that evaluation are distinct processes. To evaluate anything there are three phases to be considered: *first*, what are the general practices in regard to this thing? *second*, what items concerning these things are of greatest significance and why?—in order that we may carry out the *third* phase, which is the actual evaluation of the thing—the estimation of its worth against that which we know to be of maximum value. The emphasis in this discussion will be placed on the *how* of evaluating a nursing procedure. It aims to present a method of approach to finding out what the general practices of a specific procedure are, what items concerning this procedure are of greatest significance, and why.

The procedure which has been chosen to illustrate this method of approach is turpentine stuping. This particular procedure has been chosen because it is familiar to all, it lends itself to demonstration before a large group, and the problems which present themselves are relatively simple. Limits of time and human range of attention prohibit anything like a comprehensive discussion of all material concerned.

There are about as many ways of doing stuping as there are hospitals. Perhaps this is as it should be; however, the divergences of method in the fundamentals of the treatment are challenging.

To bring out the divergences, two good typical stuping procedures will be presented. The purpose is to present the comparative phases of these two methods, not to present them as they would be presented to student nurses.

One method has been designated Method A; the other, Method B. We would like to split these technics into three stages. The *first* stage will be called the preparation of the patient; the *second* will be the actual stuping procedure; the *third* will be the care of the patient upon completion of the treatment.

The equipment for the procedures has been listed in parallel columns with the like letters corresponding to pieces of equipment used for like purposes. In each procedure the equipment above the line is prepared and taken to the bedside; the equipment listed below the line is left in the utility room.

METHOD A

Equipment

(a) Dressing basin containing

(b) Oiled muslin with large piece of flannel to cover it.

METHOD B

Equipment

(a) Tray containing

(b) Oiled muslin with two pieces of sheet wadding to cover.

[1] Read at the January, 1930, meeting of the New York State League of Nursing Education, Section I.

(c) Dressing towels, 2.
(d) Binder.
(e) Safety pins vaseline and gauze.

(f) Stupe cloths, 2
(g) Stupe wringer.
(h) Dressing basin lined with rubber.
(i) Turpentine, 4 cc.

(j) Boiling water.
(k) Pitcher, 500 cc.

Step 1. Preparation of the Patient

(a) Bring to bedside, dressing basin with vaseline, gauze, oiled muslin, large dry stupe, binder, safety pins and dressing towels.

(b) Fold back covers to lower edge of abdomen and fold back gown over chest.

(c) Protect bed covers and gown each with a doubled folded dressing towel, place binder under back and oil abdomen with vaseline on gauze, then cover with towel and draw up bed clothing.

(d) Return to utility room with dressing basin.

Step 2. Applying Stupes

(e) Pour turpentine (4 cc.) into enamel pitcher, then pour in boiling water (500 cc.) and stir well.

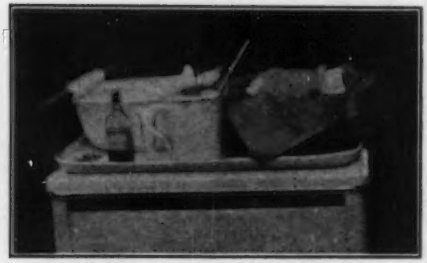


FIGURE 1.—Equipment. Method A

(c) Dressing towels, 1.
(d) Binder with half sheet and rubber rolled up in it.
(e) Safety pins.

(f) Stupe cloths, 2.
(g) Stupe wringer.
(h) Agate pail.
(i) Turpentine and oil, 1-3 mixture in medicine glass and basin with warm water. Rectal tube and urinal.
(j) Boiling water.
(k) Enamel pitcher.

Step 1. Preparation of the Patient

(a) Arrange materials on table in order of use.

(b) Turn back upper clothing to patient's waist-line. The patient raises his arms on the pillow out of the way.

(c) Place small blanket, doubled, over body. Turn nightgown up over chest and draw upper bedclothes down to pubes. Under the patient insert half sheet and rubber rolled within the binder so that the half sheet is next the patient. If the rectal tube is to be used, it is now inserted. Place a piece of sheet wadding, large enough to cover the patient's abdomen, over the turned-back fold of the bedclothing. Over the wadding the dressing towel is folded at one end and tucked over the edge of the upper bedclothing as a protective. On the towel is placed a second piece of wadding, and over this the oiled muslin.

(d) The sticks of the wringer are slipped into place and the wringer spread over the pail. One of the stupes is inserted between the folds of the wringer.

Step 2. Applying Stupes

(e) When all is ready, a large pitcher of boiling water is carried to the bedside and poured over the contents of the wringer until saturated, then the sticks are grasped firmly, held as far apart as possible, and forcibly twisted in opposite directions until there is not a drop of water evident.

(f) Place stupe in wringer and saturate with turpentine solution, then wring as dry as possible.

(g) Remove sticks from wringer and place stupe and wringer in dressing basin, cover with dressing rubber to aid in retaining heat and return to bedside.

(h) Expose abdomen, test temperature of stupe on back of (nurse's) hand, then apply lightly and gradually, using care not to burn skin.

(i) Place oiled muslin over moist stupe, then cover with large dry stupe and pin on the binder.

(j) Change stupe every 20 minutes unless otherwise ordered.

(k) To change stupe: Before removing first stupe prepare second hot stupe and bring to bedside. Open binder, protect covers and gown with dressing towels to prevent wetting, remove cooled stupe and place hot stupe. Fasten binder. The second stupe follows 20 minutes after the first.

(l) The turpentine stupe is always alternated with a plain boiling water stupe to prevent blistering of skin from too constant irritation of turpentine.

Step 3. After-Care of Patient

(m) After removing last hot stupe cover area with dry stupe and keep warm till redness subsides.

(f) Fold back the blanket sufficiently to expose the abdomen. Saturate the absorbent cotton ball in the turpentine mixture and apply, starting at the umbilicus and covering the right and left upper quadrants of the abdominal surface.

(g) Withdraw hot stupe from folds of wringer, shake out, place on backs of both hands, and apply carefully to the patient. Cover at once with oiled muslin and the sheet wadding. Raise each end alternately a few times until the patient can bear the heat. Turn down the blanket over it and prepare another stupe before the first is removed. The interchange of the stupes is made quickly by turning the blanket back over the patient's chest and turning the sheet wadding down over the towel. The stupe on the patient is picked up in the center with one hand and placed upon the wringer while at the same time the hot stupe is withdrawn from its folds with the other hand, and, with the backs of both hands, applied as in the first place. Stuping may be kept up for 15 to 20 minutes out of every hour. During the application the abdominal surface is carefully watched. Turpentine and oil are applied once in twelve hours.

Step 3. After-Care of Patient

At the end of each 20 minutes, the stupe, sheet wadding, and oiled muslin are removed, and the abdomen gently patted dry with the dressing towel which has served previously as a protector to the bedclothing, and the abdomen is covered with the second piece of sheet wadding to prevent rapid radiation of heat from it.

Remove half sheet and rubber. Adjust the binder and do not pin too snugly while distension is evident. Pull down night gown, remove small blanket, and readjust bedclothing.

NOTE.—Turpentine mixture should not be applied more than twice in 24 hours to avoid blistering and the danger of absorption.

WHAT ARE THE GENERAL PRACTICES IN REGARD TO TURPENTINE STUPING?

Items of Procedure Especially significant	Eastern Hosp.			Mid-West Hosp.			Western Hosp.		
	1	2	3	4	5	6	7	8	9
A. Ways of using turpentine:									
1. Strength if mixed with oil		1–3	1–4	1–8	1–8	1–2	1–3	1–4	1–3
2. Add boiling water to turpentine	*								
3. No. times applied during treatment:								n. s.	
(a) With every other stupe	*								
(b) With every third or fourth stupe			*	*	*	*			*
(d) Every two hours							*		
(e) Every twelve hours		*							
4. Applied warm	*	*		*	*				*
5. Applied without warming			*			*	*	*	
B. Stuping procedure:									
1. Size of area to be covered			n. s.			n. s.	n. s.	n. s.	
(a) Measurement of stupe		16–11			24–24				
(b) Large enough to cover abdomen	*			*					*
2. Temperature: (a) At which stupes are wrung out	212	212	hot	212	212	212		212	212
(b) At which stupes are applied	n. s.	n. s.	n. s.	n. s.	n. s.	n. s.	160/140	n. s.	n. s.
(c) Hot water kept on stove	*		*	*	*	*	*	*	*
Stove at bedside			*			*	*		
Stove not at bedside	*	*		*	*			*	*
(d) Hot water kept in pitcher		*							
(e) Tested on back of nurse's hand	*	*			*		*		
(f) Applied with care	*	*	*	*	*	*	*	*	*
(g) Covered with non-conductor heat	*	*	*	*	*	*	*	*	*
(h) Kept warm after applying, hot water bottle or electric pad					*	*			*
3. Duration of treatment	n. s.		n. s.	n. s.	n. s.			n. s.	
(a) 15–20 minutes out of every hour		*				*	*		
Changed every 1–3 minutes		*					*		
" " 3–5 "			*						
" " 5–10 "					*			*	
" " 15–20 "	*			*					
Frequency not given						*			*
4. Care of patient after treatment					n. s.	n. s.		n. s.	
(a) Exposure avoided	*						*		*
(b) Extra protector for abdomen	*	*		*					
(c) Abdomen washed				*					
(d) Abdomen cleaned with alcohol			*						
C. Method of wringing:									
1. Cloth wringer and sticks	*	*	*	*		*	*	*	
Length of wringer	n. s.	n. s.	n. s.	n. s.		n. s.	n. s.	n. s.	
Length of sticks	n. s.	n. s.	n. s.	n. s.		n. s.	n. s.	n. s.	
2. Potato masher					*				*
3. Wrung as dry as possible	*	*		*		*	*	*	

EXPLANATORY NOTE:—A star in any square means "yes." A blank square means "no." n. s. stands for "not stated."

Discussion of the Table

THE title of the table on page 394 tells you at once that it is an attempt to carry out the first phase of the evaluating process—*i. e.*, finding out what the general practice is in regard to turpentine stuping.

The headings at the top of the columns tell you that an attempt has been made to get a cross section of practices in this country by tabulating the information from nine hospitals distributed three in the East, three in the Mid-West, and three in the Far-West.

The list at the left attempts to carry out the second phase of the evaluating process—*i. e.*, to state the items of greatest significance in turpentine stuping. Why these are items of importance the ensuing discussion will seek to bring out.

A. Ways of Using Turpentine

THE various items with which we are concerned here are the mixture and amount used and whether it is applied warm. We have observed the data against A 1. The vacant square noted against A 1 is checked under A 2 which shows that this hospital adds boiling water to the turpentine.

In the subdivision A 3, the line having the most checks indicates that five out of nine hospitals apply the oil and turpentine mixture with every third or fourth stupe. And beside A 4 and 5 we see that some apply it hot, some apply it cold! As I survey these data many questions come to my mind. I shall present only the two most pregnant ones, however:

1. Does warming the turpentine volatilize it so completely that the turpentine is lost?
2. Which one of the two ways of using turpentine renders it more permeable?

Chemistry gives us certain facts which can help to answer each question, but the answers raise a still more difficult question. Concerning the volatility of turpentine, chemistry tells us that it is a hydrocarbon of the aromatic series; that it is an essential oil dissolved in a resin; that it is insoluble in water; that it is distilled by steam, the volatile turpentine passing off and the resin staying behind.[1]

Concerning the permeability question, it tells us that both turpentine and oil have a surface tension around 30 (just about half the lowest surface tension of water), which means that they both permeate the tissues more easily than does water.[2] *But* turpentine mixed with oil permeates more slowly than when turpentine is volatilized with steam.

And thus it appears that the knowledge necessary to estimate the efficiency of the way turpentine is used in any method is lacking until we know what temperature of turpentine solution could be used in stuping to get the desired effect and yet be low enough so that all the turpentine would not be completely lost by volatilization before the stupe cloth could be wrung out and applied to the abdomen. But there are many who believe that turpentine is unimportant in the procedure anyway. They say that it is the heat which does the work!

B. The Stuping Procedure

HERE we are concerned primarily with the degree of heat used, the area over which the heat is used, and the length of time for which this area is subjected to intense heat.

[1] *Organic Chemistry*, Remsen and Orndorff D. C. Heath Co., 1922, pp. 442 ff.

[2]

Oil of turpentine	27.1
Olive oil	33.5
Water at 0°	75.6
Water of 100°	61.5

Handbook of Chemistry and Physics, Hodgman and Lange, Chemical Rubber Co., Cleveland, 14th ed., 1929, pp. 821 and 822.

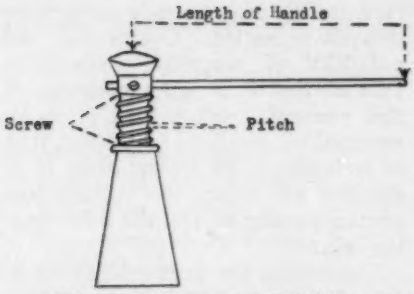


FIGURE 2.—Diagram of Jack Screw

Looking at the checks against B 1 and its subdivisions (the area considered), the scattering of them shows that sizes of area involved are varied and vague.

Looking at checks opposite B 2a shows that stupes are almost uniformly wrung out of boiling water. B 2b shows that in only one method is it known what degree of heat this has reached when it is applied to the abdomen.

Looking at B 3 the "n.s.'s" show vagueness again about this item concerned with the duration of the hot application.

The following physiological facts show why these considerations are important:

1. The quantity of blood called to this area when the body wall vessels are filled probably amounts to about one fifth that in the body.
2. The omental and subcutaneous fat makes the abdominal wall a poor conductor of heat.
3. The viscera underneath the abdominal wall are probably heated (by the rapid applications of hot stupes) to such a degree that muscular activity is stimulated in the intestinal wall. This heating comes about by actually heating the blood here and also by preventing the conduction and radiation of heat from this surface area, thus keeping this part of the body warmer than any other part of the body.

And so it appears again that the knowledge necessary to estimate the efficiency of the way by which heat is applied in any method of stuping must be sought out before this phase of the procedure is validated.

1. Given two possible ways of applying stupes: rapid applications over a short period of time, or leisurely applications over a long period of time, which secures the maximum comfort for the patient?
2. At what temperature should stupes be applied, usually, to secure the most satisfactory result?

C. Methods of Wringing

IN considering C—Method of Wringing—we have at last arrived at one point where the knowledge prerequisite for evaluating the method of wringing is available. Looking at the checks against items in C we find that prevalent practices are quite consistent. This permits us to say that everyone wrings stupes with the familiar type of stupe wringer; no one considers the size of the wringer or sticks to be essential; and practically everyone wrings them as dry as possible.

I wonder how many of you have wondered as often as I about this "dry-as-possible" business? In the stupes I myself have applied, more of them have come out dripping than dry. The thing that has made me wonder primarily is that this wringer is constructed on the same principle as a jack screw (Figure 2) which I have often been so unfortunate as to use with success in jacking up my flat tires. Now why should I be successful in lifting a 2,000-pound car with a jack, when by applying the same amount of force from my arms to the stupe wringer I cannot succeed in wringing dry one small wet flannel cloth?

When I say that the wringer and the jack screw are constructed on the same principle, the principle which I refer to is that of the screw in physics. And when I say that the mechanical

advantage of the wringer is obtained from working out the formula:

$$\frac{2\pi \times \text{length of handle}}{\text{pitch}}$$

equals this mechanical advantage, it sounds as though I had strayed a long way from home. But if I point to the illustration which you recognize as a stupe wringer in use and say, "This is the length of the handle, this is the screw, and this is the pitch of the screw," it begins to sound more as though I were on home ground. Inserting the requisite figures in the formula it looks this way:

$$\frac{2\times 3.1416\times 7''}{1''} \text{ equals } \frac{44}{1} \text{ equals } 44.$$

This means that, neglecting friction, we apply 44 times the force in our hands and arms to this stupe.

[3] *Physics of the Household*, Lynde, the Macmillan Company, 1926, pp. 16 and 17.

FIGURE 3.—The *wrong* way to fold a stupe cloth. It causes the stupe wringer to become a short wide screw with a wide large pitch. See Figure 4.

FIGURE 4.—Failure to apply the principle of the jackscrew properly. The stupe wringer here has been made into a short screw with a wide pitch and its mechanical advantage thus reduced considerably. The stupe cannot be wrung dry.

Why should not this power wring the stupe cloth dry? It will, if we reproduce the conditions in the illustration. But do we always reproduce these conditions? Suppose I fold the flannel up into a compact square bundle, put it into the center of the wringer and wring it with as much force as I can muster. It comes from the wringer dripping. The illustration shows what I have done: I have made a short, small screw with a wide, large pitch. It will be necessary to substitute a new figure here for the pitch:

$$\frac{2\times 3.1416\times 7''}{6''} \text{ equals } \frac{44}{6},$$

or only 7 times the force in our hands instead of 44 as before.

In contrast to this let me draw attention to the conditions in the wringers and method of wringing

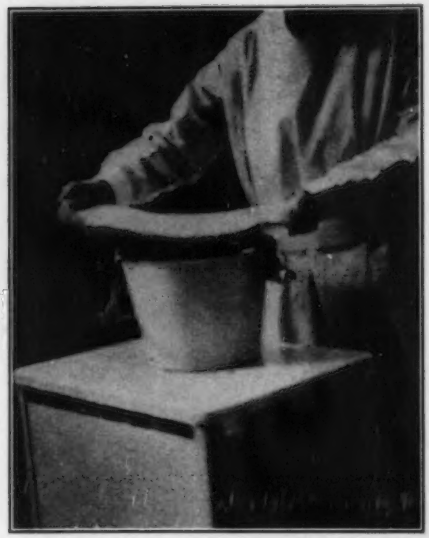


FIGURE 5.—The *right* proportions between stupe cloth and stupe wringer. The wringer is just long enough to hold the stupe folded lengthwise and just wide enough to hold the cloth folded lengthwise in thirds or quarters. It makes the stupe wringer a tall thin screw with a small pitch. See Figure 6

which will give 100 per cent performance. In the beginning, the size of the stupe must be stated.

1. The wringer should be just long enough to hold the stupe folded lengthwise.
2. The wringer should be just wide enough to hold the cloth folded lengthwise in thirds or quarters. (It should probably be one third the crosswise measure if the flannel is bulky, one fourth if light weight.)
3. The wringer should be made of a material that allows for a small pitch; for example, crash. (All of these three points directly provide for forming a small pitch.) Effectiveness in wringing decreases as pitch increases.
4. The handle should be as long as can be conveniently manipulated. The longer the handle, the less force required.
5. One handle of the wringer should be fixed when possible, if not, then the handles should be pulled away from each other during wringing.

I am sure that you see why I have aimed to present a method of approach to the evaluation of a nursing procedure rather than the evaluation of the procedure discussed. It has been necessary to leave you with questions in places where I wish very much it might have been possible to leave you with facts. This has to be, because we have not available the necessary facts and figures.

Who but nurses should collect these facts and figures, test them, and prove them, thus providing the means for evaluating nursing technics and—perhaps—improving them?

FIGURE 6.—Applying the principle of the jackscrew to the wringing of stupes in such a way that the greatest mechanical advantage is obtained. Note that the wringer has become a long thin screw with a small pitch, that the sticks are as long as can be conveniently handled and that the nurse is pulling each handle away from the other.

The Case Study

As a Method of Teaching Students and Graduates the Principles of Public Health Nursing

ELLEN L. BUELL, R.N.

[Teachers in schools of nursing will be interested in this presentation of the case study method from the public health nursing point of view. They will be interested in the statement of aims on page 400 and the extent to which they coincide with the aims of the same method when used in the school of nursing. Perhaps the most striking thing about the use of the method by public health nursing organizations is the fact that it is used as a tool for getting the job done, as well as a method of teaching the principles of public health nursing.

The case studies which are offered with Miss Buell's statement are valuable illustrations of the form and content of a case study; they are also suggestive in that they show how problems other than the immediate one which brought the nurse into the family are recognized and dealt with. Particularly useful to the student or staff nurse are the summaries at the close of each study, since they practically compel her to think about her problems in an orderly way and to judge whether she has or has not found a solution of those problems.—EDITOR.]

PUBLIC health nursing associations are obliged to admit to their staffs nurses who have had no previous experience, either practical or theoretical, in the field of public health nursing. Leaders of nursing education have not agreed upon the extent to which schools of nursing can provide this experience in the undergraduate curriculum and prepare their graduates for public health nursing. They do agree that greater effort should be made to include in the undergraduate experience an opportunity to study the patient in relation to his family and community, and to develop an appreciation of community health and social problems. A few of the schools of nursing have demonstrated that these opportunities may be provided by utilizing the hospital and community resources. While it is desirable that certain attitudes and ideals toward community health problems should be developed in the student nurse, the opportunity to study the special field of public health nursing will probably continue to be provided through postgraduate experience. Therefore it seems likely that the visiting nurse associations will continue to find it necessary to plan a program of staff education which will teach the fundamental principles of public health nursing to their new nurses.

In general we are interested in developing in each nurse an appreciation of the conditions of public health nursing and equipping her with a method of solving the problems which she meets. There is no set formula by which the problems in the homes may be solved. Unless a scientific attitude can be developed we cannot expect satisfactory work in the field of public health nursing. Thus it is that the steps in the process of solving any problem are stressed in the analysis of a family health problem; namely, the recognition of the problem, definite outlining and defining of the problem, formulation of possible solutions for the problem, selecting the solution which in this particular situation seems most feasible, application of the solution chosen, and finally judging the results in terms of its failure or its success. If these processes are consciously understood and practiced, a background of experience will be built up which will be of increasing help in the understanding and solution of problems in the field of public health nursing.

The general aims of the program of

staff education which visiting nurse associations plan for the introduction of new nurses to the field have been outlined by the Education Committee of the National Organization for Public Health Nursing as follows: [1]

1. To teach the technics and policies of the association.
2. To standardize the nursing procedures that are practiced in the home.
3. To teach the fundamental principles of public health nursing.
4. To determine the adaptability of the particular individual to the field of public health nursing.

The third aim implies that there are certain underlying principles which are either peculiar to the practice of public health nursing, or which are given greater emphasis in this field than they are in the other phases of nursing. If this is true, a study of the problems which confront the public health nurse in her daily work should provide many illustrations of these differences and offer opportunities for teaching the fundamental principles of public health nursing. The primary purpose of this article is to show how the case study has been used by the Visiting Nurse Association of Henry Street Settlement as a method of teaching the fundamental principles of public health nursing to its new staff members.

For the past three years the Visiting Nurse Service of Henry Street Settlement has included the case study as a routine part of the introduction of new nurses to the field. Each new nurse, whether a qualified graduate nurse who has been admitted to the permanent field staff, or a graduate or undergraduate student who is admitted for two months of field experience, has been expected to write one case study during the introductory period of two months. After using this method of teaching for two years, the supervisors appointed a committee to reconsider the method in the light of their past experiences and to work out more definite policies and procedures relating to its use. The main parts of the report of this committee are given because it represents the the present attitude of the organization toward the case study, and includes the instructions which guide the supervisors in its use.

The committee feels that the case study could be profitably considered from the standpoint of the development of the old staff nurse as well as the new nurse. Although study of the health problems of a family is the essence of public health nursing, very little conscious attention has been given to a special case study for the older staff nurse. In the stress of every-day demands the nurses feel the pressure for time to complete their work satisfactorily. Would it not be stimulating and worth while to the nurse, and valuable to the progress of public health nursing in general, if provision were made for each staff nurse to study intensively the health problems of a selected family?

The suggestions of this committee relate only to the case study as a method of teaching new nurses and are as follows:

Case Study

THE case study is defined as a study of the health, social, and personality problems of a family, with an attempt to analyze the problem, formulate a plan for treatment, and, so far as possible, execute the plan.

Purpose of Case Study

1. To help the new nurse to understand the meaning of family health supervision, and the interrelated social and health problems.
2. To help the new nurse to appreciate the possibilities of improving the conditions in the home.

[1] *Public Health Nurse*, August, 1928.

3. To provide through concrete illustrations the opportunity to teach the fundamental principles of public health nursing.

4. To develop a more scientific method of approach to her work.

Suggested Method of Procedure

1. Time for conference on case study:
It is recommended that the conference on the case study be presented to new nurses about the fourth week of the field experience. At this conference the supervisor discusses the purpose, the content, the type of family suitable, and the outline which suggests the form for writing the study. The completed study is due at the end of the first two months in the field.

2. Preferable type of family to be selected:
   (a) A family where the nurse expects to make several home visits, and if possible has made the first contact.
   (b) A family where health problems are predominant, and where the responsibility for health supervision is not assumed by other community agencies.
   (c) A family where there are children of infant, pre-school or school age.

3. In order to interest the nurse to begin work on her case study immediately, it is suggested that each nurse be requested to bring to the conference the record of a family in which she is interested, and which meets some of the foregoing conditions relating to the selection of the family. Following the conference, time could be given to allow the nurse to analyze this family according to the outline given her at the conference.

4. It is suggested that a weekly case conference be arranged. At this conference each nurse is expected to report the progress of her work and to receive the suggestions of the group as to the development of further plans. This conference offers an opportunity for the pooling of the experiences of all and for the discussion of general policies of public health nursing.

5. The outline of the case study is that used in the case studies presented with this paper.

In presenting the actual case studies which are submitted by new nurses, certain facts must be kept in mind. Since the case studies are submitted at the end of the first two months in the field, they represent an analysis of public health nursing problems based on very limited experience in the field. The short period of time over which the study is made does not allow for the completion of the work started, and thus from the standpoint of case studies in public health nursing they are very incomplete. The purpose in presenting these studies is to show that the analysis of a family situation offers ample opportunity to teach the applications of the underlying principles of public health nursing based on the actual experience of the new nurse. We find illustrated many times the importance of records, the principles of coöperation, the opportunities for teaching in the home, the need for considering the religious affiliation of the family, professional relationships, the principle of payment for service rendered, and the need for general family health supervision.

Case Study No. 1

Family X

Date of first contact—February 22, 1929.

Members of Family

Parents	*Names*	*Date of Birth*
Father.....	Patrick	1889
Mother.....	Margaret	1890
Children.....	Francis	Dec. 11, 1921
	Patrick	Mar. 22, 1924
	Bridget	June 22, 1925
	John	Jan. 3, 1927
	Annie	Feb. 21, 1929

Nationality—Father and mother born in Ireland. Migrated to United States in 1913. Lived in a small town in Massachusetts for eight years, coming to New York City in 1921.

Citizenship—Both Mr. and Mrs. X are United States citizens.

Economic Status

1. *Income*—Father earns $40 a week.
2. *Rent*—$26 a month.
3. *Occupation*—Mr. X is employed as a patrolman for a gas company, working from 4 p.m. to 12 midnight. Employment regular.
4. *Insurance*—Every member of the family is insured in the Blank Life Insurance Company.

5. *Fees*—Nursing care in home paid for by Blank Life Insurance Company.

Referred by—Husband called for nurse to care for his wife following the birth of Annie, February 21, 1929.

Religion— ———— Members of Church on Blank Street.

Report of Social Service Exchange—Case cleared February 22, 1929, not known to any agency.

Previous Contacts—Not known to Henry Street Visiting Nurse Service before.

Housing Conditions

1. Neighborhood—Family living in middle-class neighborhood, population largely Irish. Streets are fairly clean. The elevated runs directly in front of the apartment house. Street is very noisy; considerable heavy traffic. Blank Park is two blocks from home.

2. Halls of apartment are very narrow and dark, lighted by gas and kept fairly clean.

3. The apartment has four small rooms. The front room, the only one that gets direct sunshine, is the largest and is used as a combination bedroom and living room. The next room back is the kitchen, which is very dark, cluttered with furniture, and clothing hangs about on the walls. This room is so dark that the gaslight is needed for ordinary kitchen work during the daytime. Back of the kitchen are two small dark bedrooms with windows on a dark court. Each room has a double bed; the father sleeping with Bridget in one room—Francis and Patrick sleeping in the other. Mrs. X, John, and the baby sleep in the front living room. Ventilation is very poor—all rooms except the front room are always very warm and close. There is a small coal cook stove in the kitchen; this is the only heat for the apartment, as there is no central heating plant in the building. The toilet is in the hall, and is used by one other family. There is no bathtub, the mother bathing the children once a week in the "set tubs." The home is usually quite untidy—the kitchen sink piled high with dirty dishes and cooking utensils—soiled clothing on chairs in the kitchen and bedrooms. The beds are fairly clean. There is clothing hanging everywhere.

Brief Statement of Medical and Social Findings of Family

Upon first visit to family, Mr. X announced that he had called the nurses to take care of his wife at this confinement because the expenses of the family and general living were increasing rapidly and he was having some difficulty in meeting them. For the other confinements, they had a practical nurse to give care and do the housework. He was very much upset because the case had been reported on the previous day and the nurse had not come until twenty-four hours after the birth of the child. His attitude was quite disagreeable. The nurse took considerable time on the first visit to explain the service and the possible reasons for a late call.

Situation and Family Problems

Patients—(1) Mrs. X:

a. Diagnosis—Postpartum.

b. Medical care—Private physician delivered patient of a living female infant on February 21, 1929. The physician in charge had attended Mrs. X at all other confinements and the family apparently have unlimited confidence in his ability. The delivery was normal.

c. Nursing care—General postpartum care of mother. The patient had not been carried as an antepartum patient; consequently, on the first visit considerable time was spent in assembling supplies and teaching a neighbor her duties and responsibilities. The helper was a rather slovenly, careless individual, but anxious to assist. She showed definite progress and toward the end of the postpartum period was able to give the mother complete general care. The patient had nine postpartum visits. The physician was in the home but twice.

d. Attention to immediate surroundings:

Cleanliness—Emphasis was placed on the daily care of the patient's bed, bathing, care of the teeth, etc. Her mouth is in very bad condition and needs immediate dental care. Urged daily brushing of teeth.

Quiet—Advised keeping the children out of mother's room as much as possible and out of doors.

Ventilation of patient's room—Stressed ventilation on every visit—window usually open two or three inches. Suggested buying window ventilators and keeping windows of other rooms open from the top.

Care of bath-water, bedpan, etc.—Helper told on every visit as to their care, but apparently did not understand the reasons for their suggested care.

e. Mental attitude of patient—Mother interested and friendly. Appreciated nursing care. She tried hard to follow nurse's instructions but is physically and mentally

tired and just has too many responsibilities to carry on her duties, as she would like to. Rest period and early bed hours were urged.

Patient--(2) Annie:

a. Diagnosis—Newborn.

b. Medical care—Same as for mother.

c. Nursing care—General newborn care given by nurse for eight days. Normal condition at end of that time except that the umbilicus was slightly protruding. On the eighth visit, a demonstration tub bath was given for the mother and the following day the mother returned a demonstration bath. This was done fairly well; she seemed quite confused and many details were neglected. Many suggestions as to child care which were made by the nurse, such as regular feeding, bathing, and habit formation were absolutely new ideas to the mother. A small bed was obtained for the baby at the nurse's suggestion, and the mother plans to get quilted pads and knitted bands as advised. Need for fresh air and sunshine for baby was stressed.

Patient—(3) John:

a. Diagnosis—Stomatitis.

b. Medical care—Private physician.

c. Nursing care—During the period of daily visits to the home for the mother, John developed a "sore mouth"; the tonsils were swollen and white spots were on tongue and lips. Temperature was elevated and glands of the neck were swollen. Family were advised to call family physician, which they did. Orders were left and isolation of the child was advised. On the following day, the mother was instructed by the nurse in carrying out the physician's orders—isolation methods and general care. There were five nursing visits.

It was very difficult to keep the child in bed, but the mother coöperated fairly well and kept him there part of the time.

Diet was fairly satisfactory—liquid and soft diet advised during period of extreme soreness of mouth.

Teeth—Need immediate care—very dirty and several caries; no toothbrush.

Habits—Child still taking milk from bottle. Explained to mother the seriousness of continuing bottle and its effect on the child in later years. Also, the possibility that the "sore mouth" might be caused by dirty nipples. Promised to break child of this habit. Child sleeps with mother—advised having him sleep with brothers.

Child coöperative and friendly—His cooperation was solicited in giving up the bottle.

Other members of the family:

Father—Mr. X.

General observation and habits—A very thin, apparently undernourished, hard-working man. He sleeps very late in the morning, nine to ten o'clock, and spends most of his time after breakfast playing with the children, talking with neighbors. He is a rather domineering, self-satisfied individual. Gentle and kind toward the children, but not very considerate of his wife. Apparently he does not assist her any with household duties. He has never had a physical examination and his teeth need care.

Francis:

1. General appearance and physical findings—pale, thin and apparently an undernourished child. Had physical examination at school last fall. Teeth were cared for after that examination by private dentist. They need cleaning at present. Glasses were also obtained after the examination and he wears them constantly. Posture is fair.

2. Habits:

Sleep—To bed at 7 or 8 p.m. up at 7.30 a.m. Sleeps with brother; windows closed.

Diet—Appetite good; drinks three or four glasses of milk daily; cereal daily; vegetable and fruit regularly.

Eats meals alone, as meals for family are arranged according to father's working hours.

Care of teeth—Brushes irregularly.

Fresh air—Plays out of doors very little.

Bath—Once a week.

3. Prophylaxis—Vaccinated in infancy. Has not had T.A.T.

4. Child friendly, happy and helpful—attending Parochial School, first grade.

Patrick:

1. General appearance and physical findings—Very pale, thin, quiet child.

2. Habits:

Sleep—7 or 8 p.m. to 7.30 a.m. Sleeps with brother; windows closed.

Diet—appetite fair; drinks two or three glasses of milk a day; fruit, vegetables, cereal daily; eggs or meat daily.

Care of teeth—Brushes irregularly.

Bath—Once a week.

Fresh air—Child is sent down to the street daily with sister. There is no play space, and he spends perhaps two or three hours watching the street activity.

3. Prophylaxis—Vaccinated in infancy. Has not had T.A.T.

4. Child is noticeably quiet, shy and inactive; does not play with other children a

great deal; talks very little; few toys in the home.

Bridget:

1. General appearance and physical findings—Fairly well nourished, pale, happy child. Her flesh is firm, posture fair, skin clean and clear. Teeth clean, one small cavity.

2. Habits:

Sleep—7 or 8 p.m. to 7.30 a.m. Sleeps with father; windows closed. No rest periods during the day. Diet—Appetite very good; two or three glasses of milk a day, eggs, meat, vegetables, fruit and cereal daily. Has meals at irregular times.

Care of teeth—Brushes occasionally.

Bath—Once a week.

Fresh air—Plays on street with brother two or three hours a day.

3. Prophylaxis—Vaccinated in infancy. Has not had T.A.T.

4. Child is very friendly—apparently quite bright, gets considerable attention from father, who seems to give child anything she asks for. Mother pays very little attention to child.

Date of first visit—February 21, 1929.

Number home visits at time case study was submitted—28.

No club or clinic visits.

Supervision of family will be continued.

SUMMARY

Name	Problem	Plan	Work Completed	Work Pending
Patrick	Physical examination. Recreation. Dental Care	Physical examination at hospital. Dental Care at hospital.		Physical examination. Dental care.
Margaret	Postpartum care. Postpartum welfare. Postpartum examination. Recreation.	Nursing and medical care during postpartum period and following months. Dental clinic. More planning of home work and thus more time for recreation and fresh air.	Postpartum nursing care. Postpartum welfare visits. Transfer to Adult Health Supervision. Planning day somewhat better.	Physical examination. Care of teeth. Mother needs more help making plans and use of leisure time.
Annie	Newborn care. Newborn welfare. Health supervision.	Nursing and medical care during newborn period. Medical and health supervision of baby. Follow-up by Henry Street Visiting Nurse Service — Refer to Infant Health Station.	Newborn nursing care. Newborn welfare visits. Transfer to Health Supervision.	Registration at Infant Health Station and Health Supervision.
John	Care of infected mouth. Physical examination. Care of teeth. Prophylaxis (vaccinated, T. A. T.) More fresh air and play out of doors. Weaning from bottle.	Nursing and medical care of mouth by private doctor and Henry Street. Physical examination at pre-school clinic. Dental care at clinic. T. A. T. and vaccinated at pre-school clinic. Mother to take child to park every day. Take bottle from child.	Dental work at clinic. Weaned from bottle. Appointment given to pre-school clinic.	Registration at pre-school clinic for physical examination and T. A. T., and vaccination. Health habits.

SUMMARY—*Continued*

Name	Problem	Plan	Work Completed	Work Pending
Francis	T. A. T. More fresh air and play. Regular use of toothbrush. Open windows.	T. A. T. at clinic. To park every day for play. Interesting child in care of health and general health habits.	Play and fresh air discussed with mother frequently.	T. A. T. Health habits.
Patrick	T. A. T. More fresh air and play at regular period. Physical examination. Care of teeth. Open windows. Shyness, etc.	Physical examination and T. A. T. at pre-school clinic. To park every day for play. More attention to child by parents. Interesting child in health habits.	Referred to pre-school. Child getting outdoors more, but not to park. Discussed problem of shyness with both parents.	T. A. T. and physical examination at pre-school clinic. Health habits.
Bridget	Physical examination and T. A. T. Less attention from father. Sleep alone or with mother. Care of teeth. Play at regular periods in park.	Physical examination at pre-school clinic. To park every day for play and fresh air. Interesting child in health habits. Sleeping with mother.	Referred to pre-school clinic. Discussed frequently with mother need for fresh air, sleeping alone, and less attention by parent.	T. A. T. and physical examination at pre-school clinic. Health habits.

Case Study Number 2

Family C
Members of Family

Parents	*Date of Birth*	*Color*	*Country of Birth*	*Religion*	*Education*	*Citizenship*
David...	1901	Black	B. W. I.	———	Grammar school	1st papers
Evelyn..	1904	Indian	B. W. I.	———	Grammar school	No
Children						
Enid....	1922	Black	U. S. A.		2nd Grade	
Sylvia...	1923	Black	U. S. A.		1st Grade	
May....	1926	Black	U. S. A.		Pre-school	
Harry...	1 week	Black	U. S. A.		Infant	

Economic Status

David, the father, came to U. S. A. eleven years ago in order to study dentistry, but lost all the money given him by his father, due to bank failure. He is the only one in the family earning any money, and he makes only $20 a week plus tips. He is an elevator man and also porter in downtown district.

They have living with them a cousin of the husband, who washes dishes in a restaurant and who pays the family $3 or $4 a week when he can. They pay $60 a month rent for a six-room apartment; would like to rent another room, but have not been able to as yet.

Mother, father, and Enid have Blank Life Insurance policies.

Source of Call

The family was reported to Henry Street Service by a Maternity Clinic. The mother was carried for antepartum supervision and postpartum care. This is the first contact with the family.

Report of Social Service Exchange

They are unknown to any other agency.

Conditions Found in Family at Time of Present Contact

The apartment is in a colored section, very clean and airy, but fairly noisy, due to the fact that there is a garage on right-hand side. Only two rooms have outside exposures.

The children are well nourished, well dressed, and fairly well behaved. Mother keeps the apartment very clean.

The mother was carried as an antepartum case and was very coöperative. She had her trays all ready as well as pads made, and carried out instructions given. She is a very good mother, devotes all her time to her family and home.

The home atmosphere is very pleasant; the father is interested in the welfare and care of children and wife. They manage very well on small income.

Mother and children are being cared for in absence of nurse by a friend of the family. The father takes care of them at night. The

SUMMARY

Name	Problem	Plan	Work Completed	Work Pending	Probable Solution
David	Insufficient income.	To interest father and mother in trying to find less expensive apartment			
Evelyn	Antepartum supervision.	Make visits as necessary.	Supervised during antepartum period. Help patient make necessary preparation for baby and care during postpartum period.		
	Need of nursing care during postpartum period.	To make daily visits and instruct helper about care in absence.	Daily visits made by nurse during postpartum period. Helper instructed.		
	Unable to persuade children to help with housework.	To try to help mother by getting children interested in helping nurse.	Children's interest gained in helping with housework and errands.	Visits to be continued to help mother in securing children's help.	
Enid	Enlarged tonsils.	To secure consent of parents for medical examination.	Have given mother slip to ———— Clinic.	Examination.	Mother will take her to clinic as soon as she is able.
	Need of dental care.	To teach the child proper care of teeth.	Have secured child's interest in brushing teeth every day. She also supervises the younger children brushing their teeth.	Dental care.	Will probably be referred to dental clinic from medical clinic.
	Not interested in helping mother.	To stimulate a feeling of responsibility in helping mother with housework and care of younger children.	Is beginning to help with work and with care of younger children. Teases children much less. Child is getting other children to help.	Continued encouragement.	

helper is very coöperative and enjoys the children. The mother has not had medical care except during pregnancies.

The three older children sleep together. Mother says they cannot afford an extra bed for the younger child. The arrangement works out badly, as the two older children get great satisfaction out of teasing the youngest child. They wet the bed and blame it on the younger child.

The family have very few friends and cannot afford outside recreation. The father is a member of the American Legion, having been in the American Army overseas for three years.

SUMMARY—*Continued*

Name	Problem	Plan	Work Completed	Work Pending	Probable Solution
Sylvia	Enlarged tonsils.	To have medical examination.	Have secured mother's permission for examination.	Medical examination.	Have given mother slip to Medical Clinic and will take her as soon as able to.
	Proper care of teeth.	To teach child proper care of teeth. To send to dental clinic.	Brushes teeth every day.	Dental examination.	Will be referred from Medical Clinic.
May	Enuresis.	To try to secure child's interest by means of star chart. To instruct helper in limiting fluids after 4 P.M., etc.	Child very much interested in chart. Is having more dry than wet nights.	Further visits to be made to encourage child.	
	Temper tantrums.	To try to make family see the danger of teasing the child and calling her naughty.	Has fewer tantrums. Older children's interest has been secured. Child is teased much less.	Mother has been instructed in isolation method, and as soon as she is able to take charge of the household again will try it.	
	Separate bed.	To suggest putting in vacant room.		Mother not yet persuaded—afraid of mattress, etc.	
Harry	Nursing care.	To make daily visits and instruct helper in care when nurse away.	Daily visits made. Helper gave good care in absence of nurse. Mother given demonstration bath.		
	Need of starting child on regular health habits.	To make supervisory visits, until child is 31 days, to help mother in establishing habits.	Child is being supervised regularly.	To continue supervision. To secure mother's interest in registering child at baby health station.	

Date of first visit, April 26, 1929.
Number of home visits at time case study was submitted—9 antepartum visits, 11 postpartum visits.
No club visits.
Supervision of the family will be continued.

The English Midwifery Service

HESTER VINEY, S.R.N.

THE history of midwifery practice in England is an interesting one since, although the profession has always included women of very varying grades of education and status, yet it has at all times attracted into it women of fine ideals and inspiration to whom its responsibilities and potentialities have made a strong appeal.

The midwives themselves made several attempts to regulate their profession, but official recognition of their office was not given until the Act of 1902 definitely laid down the conditions of their employment: this Act was largely the result of the work done by the midwives through the Midwives' Institute.

The work of the midwife differs greatly from general nursing. The midwife bears the heavy responsibility of two lives, that of the mother and that of the child. She practices, in normal cases, without the doctor to advise or assist her, and she deals with a normal physiological process instead of with a pathological condition. These differences have to be appreciated in order to understand the legislation connected with the midwifery service.

The Midwives Act of 1902

RECOGNITION of the importance of this service was given by the Midwives Act of 1902 under which a Central Midwives Board was constituted, consisting solely of nominated members, whose duties are to carry out the provisions of the Act. The Central Midwives Board approves courses of training in midwifery and conducts the examinations conferring the qualification of midwife. A roll of midwives is kept by the Board and two types of midwives are enrolled:

(a) *Bona-fide* midwives whose practice was approved and who were not expected to pass the qualifying examination.
(b) Since the Act of 1902, midwives who have taken an approved course of training and passed the qualifying examination.

Women whose names are not on the roll of midwives are forbidden by law to practice midwifery.

The Board laid down definite regulations respecting the practice of the midwife, defining as closely as possible the scope of her office and her responsibilities. Midwives who contravene these regulations come under the jurisdiction of the Board, who hear the facts of the case and, where malpractice is proved, have the power of removing the name of a midwife from the roll and of restoring it on the application of the midwife herself, if and when she satisfies their requirements. The midwife has the right to be represented at any such inquiry by a lawyer and has also the right of appeal to the High Court against any decision of the Board in the case of the removal of her name from the roll.

The regulations laid down by the Board had to be submitted for approval to the Privy Council until the establishment of the Ministry of Health in 1919 which took over these powers from the Privy Council.

The actual supervision of the midwife is given under the Act of 1902, to the local authorities of the county and the county borough councils: these authorities are called in the Act by the title of Local Supervising Authorities. In 1902 they were given the power of delegating their functions to the smaller district councils within their areas. This power of delegation was repealed in the 1918 Act and, in spite of active protest by the

midwives' and nurses' professional associations, has again become permissive under certain conditions in the Local Government Act of 1929.

The Local Supervising Authorities are given the duty of exercising a general supervision over the way in which the midwives carry out the regulations of the Central Midwives Board. They have to investigate cases of malpractice, reporting on the midwife to the Board. They also are obliged to maintain a list of all the midwives practicing in their area.

The midwife on her part is obliged to coöperate with the work of the supervising authority. Under the Notification of Births Act 1907–1915 the birth of each child must be notified by the father, if resident in the house at the time of the birth, or by any person attending upon the mother, within six hours of the birth. This notification is sent to the Medical Officer of Health of the Local Authority and, under the rules of the Central Midwives Board, the midwife is bound to notify her Local Supervising Authority of certain conditions if and when they occur in her practice and in this way the authority is kept in close touch with her service.

The Midwives Act of 1918

IN 1918 a second Midwives Act dealt with some of the anomalies and difficulties which had arisen under the former Act.

Under this Act the Central Midwives Board was empowered to meet the expenses of midwives called upon to defend their cases before the Board; the Local Supervising Authorities were empowered to suspend midwives from practice pending a judgment by a Court of Justice or by the Central Midwives Board; adjustments were made between the work of the midwife and the doctor.

In 1918 the war came to an end and the period following the Armistice was one in which the old resistance to change in England was to some extent broken down. The nation was ready to review its life and method of government in a critical mood and the blessed word "reconstruction" was heard on every side.

Conditions of life were greatly altered since the passing of the original act of 1902. The nation, sadly aware of the war losses and genuinely alarmed at the infant mortality and morbidity rates and at the revelation of national ill health made by the army medical examinations on the one hand and by the school medical service on the other, was ready to foster progress in the public health services.

In 1907 and 1915 acts had been passed, at first permitting and later insisting upon the notification of the birth of every child to the Local Medical Officer of Health.

The Maternity and Child Welfare Act of 1918 gave the widest possible powers to the Local Authorities for the welfare of the mothers and children. The political influence of women, newly enfranchised, was felt in each advance, and the abolition of the Local Government Board and the establishment of the Ministry of Health in 1919 enabled some order to be achieved amid the chaos of the overlapping authorities and functions.

On the nurses' side, the Nurses' Registration Act of 1919 established the General Nursing Council and a standard of qualification for the nurses who were permitted to register themselves on satisfying the conditions laid down under the Act. A new emphasis was laid upon the certificate of the Central Midwives Board, and it has become usual for general trained nurses to take this qualification in addition to their hospital certificate.

In the meantime the Local Authorities, encouraged by grants from the Ministry of Health and by the popular demand, extended the maternity and child welfare work under their public health schemes and appointed as health visitors, trained nurses holding the additional midwifery qualification. These officials became responsible, amongst other duties, for supervising the health of mothers and of children under five years old.

One more authority had arisen since the 1902 Act in the Approved Societies who carry out some of the terms of the National Health Insurance Acts of 1911–1928 and who are made responsible for the administration of the cash benefit (30/– at first and later £2) paid to the insured women and to the wives of insured men at childbirth.

The midwife of this new period found herself an integral part of a growing national scheme for the protection of the mothers and children. Her service tended each year to come into more intimate contact with the public health and hospital authorities and her work to be publicly recognized and appreciated as of national importance.

The Maternal Mortality Rate

FROM 1918 onwards, the question of the maternal mortality rate attracted public attention, and its persistently high level in face of so much effort in the direction of health for mothers and children aroused alarm and criticism. The infant mortality rate had fallen with dramatic suddenness, but the maternal mortality rate remained and still remains from 4 to 4.42 per 1,000 confinements.[1]

Public attention concentrated upon two aspects of the question: upon the whole practice of midwifery as it concerned the health of the mother and upon the environmental conditions under which the mother lived and in which the confinement often took place. These inquiries led on the one hand to a new Act of Parliament dealing with midwifery and on the other to the Housing Acts and schemes which, it was felt, would relieve some of the hardships inflicted by the war restrictions upon building.

The Midwives and Maternity Homes Act 1926

THE Midwives and Maternity Homes Act of 1926 was designed to strengthen the existing law to prevent unqualified women from practicing midwifery. Minor points of finance were dealt with and an important section of the Act defined the conditions under which maternity homes were permitted to be established. By this Act all homes in which women are received for confinement must be registered by the Local Authorities and inspected by them. Registration may be refused unless the conditions laid down are complied with and these conditions include the proper qualification of women responsible for conducting the confinement and the general sanitation and construction of the building and the conduct and organization of the home.

A further Act secured the registration and inspection of all nursing homes.

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[1] The maternal mortality rate for the U. S. birth registration area (44 states and the District of Columbia) for 1928, the last year for which figures are available, was 69 per 10,000 live births. Iowa reported the lowest rate, 48 maternal deaths per 10,000 live births. Utah was the only other state with a rate under 50. Arizona, Arkansas, Delaware, Florida, Pennsylvania, Vermont, West Virginia, and Wyoming reported the lowest rates since their admission to the area.—*Editor.*

Local Government Act of 1929

IN 1929 a Local Government Act of widely reaching influence was placed on the statute book. By this Act the overlapping functions of the ancient Poor Law Authorities and the Local Government Authorities were adjusted by the abolition of the separate Poor Law Authorities and the incorporation of their functions of the administration of the Poor Law with the general work of the Local Authorities. The Local Authorities will now take over all the institutions formerly maintained by the Boards of Guardians which include the large and often well equipped Poor Law Infirmary Hospitals. Many of these hospitals have maternity departments and have been recognized as midwifery training centers.

The Local Authorities are therefore in a position to combine many diverse health schemes into one coördinated effort to maintain good health in their areas.

They are now responsible, amongst other important duties, for the health of the mothers and of children under school age, through their health schemes; for education, through their education committees; for the provision of hospitals for physical and mental disorders and for the provision of many forms of relief in poverty, old age, and sickness. Many Local Authorities at the present time maintain efficient maternity homes or provide maternity beds in hospitals.

In this advance in local government the certificated practicing midwife has a place of importance, and a sincere effort is being made today to define the part that she will have to play in the future expansion of the health services.

Midwives are at present employed under a number of different authorities and there is a notable variation in their remuneration and status. The Queen's Institute of District Nursing and the independent district nursing associations employ a large number of nurses who are also midwives and who practice as general nurses and midwives or as midwives only; local authorities, as county boroughs, for example, employ salaried, whole-time midwives in some parts of England.

Hospitals with maternity departments and district areas employ midwives who staff the maternity ward and department and supervise the work of the pupils and teach the practical work of midwifery, and there are also a large number of independent midwives practicing by themselves or in partnership.

Report by the Ministry of Health

THE Ministry of Health has recently appointed two departmental committees to make an exhaustive inquiry into the midwifery service and into the whole problem of the maternal mortality rate. Of these committees one has already published a report[2] suggesting the lines upon which advance may be made in the existing midwifery service.

Recommendation for a National Scheme

THE recommendations of this first report aim at improving the education and supervision of the midwife. Many suggestions are made for the improvement of the conditions of her employment and of her remuneration and pension. The report recommends a larger sphere of influence over the midwife by the Ministry of Health.

[2] Report of Departmental Committee on the Training and Employment of Midwives, Ministry of Health, Reference No. 32–286, His Majesty's Stationery Office, Kingsway, London, W. C. 2. Price, 1/–.)

These recommendations would definitely restrict the present powers of Central Midwives Board, but leave to it the conduct of examinations qualifying the midwifery candidates and the present penal powers. The report is now the subject of much discussion, professional opinion being strongly on the side of self-government.

For the midwife herself great emphasis is laid upon her part in antenatal care of the mother, and the report visualizes a scheme on a national basis which, by incorporating into it the National Health Insurance and Local Government public health schemes, would ensure to every mother, under whatever circumstances she was placed, a complete organization designed for her own welfare and for that of her child. The British Medical Association, who have also dealt with this question, have produced their own scheme in which the same ideal is expressed, but prominence is given to the service of the general practitioner and of the midwife rather than to any expansion of the public health scheme.

The reports of the medical committee now sitting upon the maternal mortality rate are eagerly expected and it is hoped will lay the foundations of an efficient national method of caring for the mothers and children of England.

The way has been long and hard which the English midwife has had to tread, but she has been fortunate in the inspiration and idealism of her leaders.

The brighter future which some of the legislative changes seem to offer her will have been won very largely by those leaders who have devoted themselves for so many years to the question of midwifery training and service.

Maternity Institutes

THE object of the Maternity Center Association of New York is to teach people the value of and need for adequate maternity care and to help secure that care for expectant mothers. The Association has always felt that time spent in educating nurses was time profitably spent, so as far back as 1919, the field experience was provided during the summer for nurses who were interested in maternity care. With the passage of the Sheppard-Towner Bill and the demand for nurses with maternity experience, the Association developed its activities on a basis which made it possible to give supervised experience to nurses.

In October, 1929, in order to extend this education of nurses, a program of institutes was developed that Maternity Center methods might be described and demonstrated to nurses in their own communities. Anita Jones, one of the Assistant Directors, was assigned full time to the institute work. These maternity institutes are conducted in three or four two-hour sessions arranged to suit the convenience of the local group which sponsors the institute. Each institute includes a general discussion of the maternity situation and the part the nurse may play in improving maternity care; a brief review of delivery and postpartum care and a detailed discussion of mothers' classes. Demonstration equipment is carried and set up for each institute, so that the nurses attending the institute may examine the teaching equipment and learn just how each thing is used and why that particular type is urged.

The institutes are held wherever they are requested provided a registration of at least fifteen nurses can be expected. An effort is made to limit the groups to a maximum of fifty. Where more than fifty nurses wish to attend, two institutes are arranged for. The nurses pay an individual registration fee of $3, or the institution or organization which requests the institute may pay the registration fee. Where the fee of $3 per nurse seems too much, or where another plan might seem advisable, an adjustment can be made.

Institutes have been conducted in the following states: Virginia, West Virginia, Pennsylvania, New York, New Jersey, Connecticut, Colorado, California and Oregon. These institutes have been sponsored in some instances by the State Department of Health, by the Extension Department of a University, by the local Visiting Nurse Association, by the State Organization for Public Health Nurses, and by unorganized groups of public health nurses.

Utilizing the Antepartum Record

NAN H. EWING, R.N.

THE use of medical records of which the nurse's clinical record is a component part is being encouraged by clinicians more than ever before. If a medical record is to be usable it must be valuable and to be valuable records must be produced by well trained workers. In medical history work both doctors and nurses are prone to take one of two attitudes. They either insist that case records be minutely complete, or they ignore to some extent the details which have an important, if indirect, bearing on the chart. The possibilities for research in the data are often overlooked by hasty recorders, and all too often we are only passively aware of the legal value of the record.

We in nursing education have to face two factions when we perform the apparently simple act of teaching nurses charting and chart interpretation. The fundamentalists say that the nurse is a handmaiden of the doctor, a lowly handmaiden indeed, and that she must stay within her narrow sphere. They are willing that her record be part and parcel of the required data. It is customary, harmless, and valueless. These doctors believe that nurses need willing hands and happy hearts, but no other equipment. If we accept this theory it will be wiser to discontinue writing worthless reports.

The modernist may either wish to eliminate the nurse's findings or he may demand such an elaborate record that the nurse with scant knowledge of her subject will be incapable of rendering him a satisfactory report.

We should like to be, I believe, in all phases of nursing, neither in the dark depths of ignorance nor on the arid heights of medical science. In other words, the well educated nurse knows that her best ground is in her own province. The far-off fields of the doctor's domain may appear inviting, but the wise nurse knows that she will not lack opportunities in her own realm, and we may all be thankful for the comforting class of doctors who stand between our provoking fundamentalists and our exacting modernists. These men see in the nurse's record a valuable contribution to the medical history and find in it an indispensable aid to diagnosis.

Passing over this long preamble and focusing on the subject of antepartum service records as a type of clinical records, we are faced with these questions germane to the topic: Are nurses prepared to produce usable records during the antepartum period? Are they properly taught to interpret the companion pieces of the chart, *i. e.*, the pregnancy, personal history, and labor summary blanks? If so, is there an appreciable improvement in the quality of these records and are the doctors obtaining any real help and information from them? The answers to the questions will give a clue to the general type of maternity service conducted. They will be indices of the attitude of the doctors doing obstetrics, the alertness of the nursing staff, and the capability of the students to profit by their instruction. And, equally important, in these answers will be reflected the type of service given to the patient.

The careful correlation of facts set down in the personal and pregnancy record will be invaluable to the nurse as well as to the doctor. This correlation is requisite if the nurse wishes to aid the doctor intelligently and if she

wishes for her own sake to know something above and beyond the ordinary mechanical motions of nursing care. The modern nurse, as a woman, should have a natural interest in the new generation. By a careful study of the cases coming under her observation, and a comparison of the normal and the abnormal, she will understand better and appreciate more the importance of eugenics. Hygiene of pregnancy will have a new significance. Physical inheritance will have a different meaning. She will feel more reverential toward science which has made it possible for countless children to be well born. She will be enlisted by her interest in the work that is to be done for the women of all races as well as for the children who are potential mothers.

She will be touched, perhaps, in her varied prenatal service, to meet with colored patients—women who have hip deformities, rachitic pelves, etc.—who have, with the aid of skilled obstetricians, delivered children who will never be handicapped physically as were their mothers. A black mother, with a beaming face, represents a type seen at prenatal clinics. Her children, if it is humanly possible, will not be rachitic and will not be deformed by osteomalacia. Dr. De Lee calls attention to the fact that nurses should appreciate how comprehensive prenatal care is. He says that it begins before the girl baby is born, extends through infancy, childhood, puberty, and marriage. In short, to get the most out of obstetrical nursing we must see beyond even skilled mechanical care. We must appreciate the social and biological significance of the work.

Scanning the standard Form 7 of the record prescribed by the American College of Surgeons for pregnancy, we note the items: age, race, and occupation. All three are important; each has a definite bearing on the prognosis of labor.

The family history is important, but even more so is the record of previous illnesses. If a patient has been a regular attendant at a clinic or has been under the care of a capable obstetrician, we can look for a complete history. Many women wait until the last few weeks before delivery to consult a doctor and then they regard as unimportant many facts that are of consequence. The gravida who has had a comparatively recent illness involving the heart, lungs, or kidneys, becomes, of course, the object of special anxiety to the obstetrician and of highly intelligent prophylactic nursing care. The number of living children should interest the nurse. The history of previous deliveries which should be written in detail on the pregnancy record is revelatory and should not be overlooked. The duration of these deliveries reminds us that history repeats itself in obstetrics also. Normal deliveries are most often followed by normal deliveries. One precipitate may mean another. Diagnosis of position and presentation should be noted by the nurse as soon as possible. The teaching supervisor can show the student how this knowledge will help her to locate the fetal heart tones and to estimate with a fair degree of accuracy the type of case she will be caring for.

The attitude of the supervisor is highly important. First of all she must know herself. Then she must take a delight in sharing her knowledge with her students. Nurses are too often concerned with obstetrical nomenclature for the purpose of passing examinations. Some see in obstetrical nursing in any of its three aspects nothing but drudgery. This lack of interest in scientific detail in obstetrical

nursing often goes back to teaching. Often the class work in obstetrics is presented before or after the nurse has had her practical experience.

In case of the former we have an educational evil which is bad enough, but in case of the latter we have a greater one which precludes the possibility of nurses doing professional work along these lines. Often obstetrical nursing is taught by one who is not prepared to teach her subject, and the course resolves itself into a series of questions and answers which may serve the purpose of passing a state board examination but which fail utterly to assist the nurse in doing skilled and scientific nursing.

The nurse should become familiar with the normal pelvic measurements. While pelvic mensuration belongs almost exclusively to the doctor, the nurse can use this information. Doctors prescribe medications, but we teach nurses materia medica. The time will surely come when nurses will pay much more attention to pelvic measurements. Dr. De Lee has added to his new text of obstetrical nursing a discussion of pelvic mensuration. If the nurse knows the normal measurements and a few general rules for interpretation of comparative measurements, she will bring a different attitude to her work. Dr. De Lee cites this case, among several, for illustration:

Dr. De Lee says:

> The nurse will readily note that in the case of Mrs. A all the dimensions are smaller than normal. Mrs. A has therefore a generally contracted pelvis or justominor pelvis . . . , and if the baby is normal in size or larger than normal she will have a difficult labor. If the baby is a very small one it may go through the canal safely.[1]

Several other cases are cited which give a clue to the type of labor which the nurse can prepare for. If the patient has a justomajor pelvis, that is, an abnormally large one, the baby may come through very quickly. The nurse knows that this will be accompanied by excessive tearing of the soft parts and she will watch this patient just as carefully as she watches the case with a justominor pelvis.

A model chart, containing a list of the requisite items to be reported as routine and a list of the special items in certain conditions, should be set up in the birthroom. The normal measurements and the approximate hours for each stage of labor should be listed, in order that the nurse may make her comparisons and deductions easily. In addition the head nurse or supervisor in the birthroom should make a case study or analysis with the students as soon as she has consulted the obstetrician. Students should be taught the importance of fetal heart

[1] From *Obstetrics for Nurses* by J. B. De Lee, M.D., by permission of the publishers, W. B. Saunders Co, Philadelphia.

CASE OF MRS. A

			Normal	*Mrs. A's pelvis*
External—Between iliac spines	Sp. I.	23	26	−3
Between iliac crests	Cr. I.	25	29	−4
Between trochanters	Bi. T.	27	31	−4
Baudelocque's diameter	D. B.	18	20	−2
Internal—Conjugata diagonalis	C. D.	10½	12½	−2
Est. conjugata vera	C. V.	9	11	−2
Between spines	Bi. Sp.	9	11	−2
Between tuberosities	Bi. Isch.	8	11	−3
Pubis to sacrum	S. P.	9	11½	−2½

tones and should be given rules for recording them. They should know how to interpret an increase or decrease in rate, volume, etc. Intake and output records should be kept on cases with tendencies toward eclampsia. Output should be measured for all cases. And let the nurse not forget the application of the facts to the case in hand. A primipara with a contracted pelvis in an excessively long first stage of labor will not be merely a tired, impatient woman but a case requiring special care and consideration.

Seeking the sanction of an expert upon the views expressed in this article, the writer asked Dr. J. P. Greenhill of the Chicago Lying-In Hospital for a critical comment. Dr. Greenhill shares with Dr. De Lee the opinion that the nurse has a high place in the antepartum period. He believes that the nurse should be taught the possibilities of utilizing the antepartum record. Dr. Greenhill says, in part:

> I would emphasize more the careful scrutiny of the prenatal history with special attention to the heart and lungs. During labor I would urge the nurses to have the patient urinate more frequently and to see that she has a bowel movement or enema every twenty-four hours. The nurse should see that the patient takes fluids and nourishment during labor because most patients neglect this unless forced to it.

Dr. Greenhill believes that the prenatal record or the record made by the doctor and the nurse during labor is suggestive of knowledge and skill and that it has tremendous possibilities.

In some rural communities where doctors are few, the highly trained, self-reliant nurse is doing work that in towns and cities belongs to the doctor. Mrs. Breckenridge's courageous corps of nurses is doing notable things; they are practicing scientific midwifery and are being richly rewarded, not only by highest praise, but by results which have a sociological as well as a medical significance. Until very recently nurses who wished to learn the highest type of obstetrical nursing, with special reference to midwifery, were compelled to go to England or elsewhere out of the United States. Now such courses are available here. But in our own maternities, where we do not charge the nurse with such grave responsibility or important decisions, we can lay a foundation. We can give a serviceable type of education; we can use our case studies for illustration; and we can show a practical application of obstetrical knowledge to ends which cannot be recorded.

Can Maternal and Infant Mortality Be Reduced?

VALUABLE indication that fewer mothers and infants die among those reached by public health medical and nursing services is contained in certain figures just compiled for the child health demonstrations of the Commonwealth Fund.

During the four-year period covered by this special study there were 10,444 births in the four demonstration communities. In 2,518 cases, about one-fourth of the total, nurses of the health department gave prenatal instruction and supervision in coöperation with the family physician. In the group under such supervisory care there were only eight maternal deaths in comparison with sixty in the group not served, sixty-five stillbirths in comparison with 383 in the group not served, and forty infant deaths under one month in comparison with 297 in the group not served.

In these four communities 6,234 infants between one month and one year of age had either field nursing service or medical supervision in health centers, or both, while 3,425 infants did not have such care. There were 113 deaths in the group served, and 163 in the group not served. Where care was given the infant, mortality rates were especially low for congenital causes, respiratory diseases, diarrhea, and enteritis.—*Health Officers' News Letter*, American Public Health Association, November 22, 1929.

Problems of Administration[1]

S. LILLIAN CLAYTON, R.N.

ORGANIZATION and administration go hand in hand and, therefore, the first problem confronting an administrator in a school of nursing is related to the type of hospital organization of which the school is a part. Sound organization, combined with efficient administration, transforms any institution from the haphazard of chance almost to the certainty of a science. The hospital organization should be the coördination of thought, purpose, and united action of all its departments for the attainment of definite results. Success in the administration of the school of nursing depends partly upon this scheme of sound organization, though it must be borne in mind that the most complete system of organization may be entirely ruined by incompetent administration. Effective organization is imperative; efficient administration is essential. By administration I mean administration of human affairs, and the one common element in all enterprises, and the most important, is the human element. Therefore, the proper selection and direction of personnel for the school of nursing and for the hospital is obviously the most important requirement to ensure efficiency in the management of affairs.

It has been said, "The science of efficiency is nothing but the most common-sense way of doing a thing, and common sense is a matter of the mind, and the mind is man." So that real efficiency is attained by the mind controlling and directing effort into proper channels. Obviously, the mind of an administrator should be continually developing, but should be, at all times, a clear, well ordered mind, open, wholesome, inviting and receptive; a mind reflecting and radiating. Whatever there is that is great in the world has been done by the individual. All the resources that make for material progress have been the work of individual initiative, goaded on by pride and stern necessity. Therefore, in our planning and perfecting of methods, let us aim to select, to direct our organization, the individual who is prepared for the work to be done, by possession of a suitable personality and by education and experience. Let the hospital organization, in its planning and perfecting of methods of administration, aim to encourage and make possible the further development of the individual, so that she grows with the growth of the organization.

The leader in this organization scheme will apply the same principle of administration to the personnel of her department, realizing that every individual needs time to grow and must have the capacity for growth, but if the growth of the individual is not fertilized with work, she will develop only into a weed of a worker. There are weeds in our personnel hindering the growth of good supervisors and workers, just as weeds choke the growth of good crops.

In order to live and grow, one has need of an horizon extending beyond her vocation. Our great profession, with its educational program for the ultimate conservation of the health of the people, provides this vision for us. There must be provision for growth in service, if narrowness is to be eliminated from our administration. The individual member of the profession

[1] Given at the twenty-fourth annual convention of the Missouri State Nurses' Association, October, 1929.

reaches her highest development by studying her personal characteristics and talents, and cultivating them thoroughly. No form of control in any organization should be permitted to overlook this individual development.

Napoleon pointed out that it is not men, but the man who is everything. It was Cæsar who conquered Gaul, and Hannibal who made Rome tremble. The history of famous armies is the history of great generals, for no army has ever achieved great things unless it has been well commanded. Great men, not great causes, have made and destroyed nations. The genius of Foch, in the world's crisis, shines forth, commanding the admiration of friends and foes the world over. But let us hear the testimony of the Great Marshal. Foch said:

> I do not believe in the stroke of genius that turns the fate of battle. Battle is a complicated operation. You prepare laboriously. You think out every possible development and decide on the way to deal with the situation created. When one of these developments occurs, you put into operation your prearranged plan. Every one then says, "What genius to have thought of that at the critical moment"—whereas the credit is really due to the labor and preparation done beforehand.

That is the logical explanation of the vision, initiative, judgment, decision, self-reliance, and drudgery that crystallize into what we call "genius," or ability to meet wisely our various complicated organization problems.

Preparation is the foundation of success, and remember that the greatest professional unhappiness is "disqualification in the face of opportunity."

Emerson said, "Every great institution is the lengthened shadow of one man." It could, in some instances, be better described as the diffused radiance of one man. The right influence will permeate an organization from the top down, quickening and stimulating the powers of each individual. The real leader unfolds the vast vistas of possibilities in the work and kindles in her personnel the incentive to attain them.

The thought, feeling and interest of such a leader are not confined to her relations with her immediate staff; they course down through all the ranks, for she knows that the worth and usefulness of a personnel are determined by its characteristics.

Given an administrator having suitable preparation and possessing qualities of leadership, the problems that arise from lack of high aspiration for the organization, and those that come from selfish ambition, will be absent. Such an administrator will possess ideals which create an absorbing passion for accomplishment — a constancy of purpose which masters many difficulties. Such leadership will emphasize the fact that idealism in administration is the important thing when backed by sincerity, by a meritorious and definitely conceived purpose, and by a practical scheme for its application to daily problems.

The success of our schools depends upon a few basic principles: first, effective organization of the hospital and the school; second, efficient administration; third, individual proficiency of the personnel; fourth, a proper budget and its wise use.

Individual proficiency is the foundation of organized efficiency; therefore, the proficiency and adaptability of each individual is required for complete success. Many problems of administration may be eliminated, if the environment provided for the personnel is adequate; adequacy to include provision for comfort, relaxation, and recreation. The salutary influence of proper environment contributes to the upbuilding of the

individual and the development of useful power.

There is so much discussion today concerning lack of time in which to meet our personal and professional obligations. Especially is this true in a school administration where the leaders in the organization have a three fold obligation,—to business, to education, and to their function as advisors to students. Many problems would be averted and much opportunity provided for study, thought, and recreation if some of the world's business principles were brought into our daily administrative program.

The value of time and the proper use of it should be impressed upon all, and the standards of service should determine whether the working time is properly utilized. Supervisors must concentrate their powers upon matters under consideration. The ability to make prompt and proper decisions is one of the real tests of an executive's ability.

The divided mind lacks force; the habit of concentration gives strength. The limitations of time are fixed, but the methods of utilizing time are susceptible of continual improvement. The capable executive aims to apportion his work to meet the demands of the day, to adjust his relations to others to express harmony and good will, and at the same time to keep everything well balanced and impregnated with the spirit of human kindness.

Looming large in our list of problems of administration are those classed as personality problems. To meet these adequately, one should have a substantial knowledge of psychology, a desire to understand the individual, a vast amount of patience, and a knowledge of life as it is. In addition to this we may again bring in good business principles.

The selection of personnel, and the daily contacts with them, requires a balanced mind and a sympathetic tendency to see the world through the other person's eye. To meet every one upon a common ground, one must first give up prejudices. The care of the patient and the growth of the profession must be the governing principles in the relationship between the various members of the organization, and thus will be eliminated many problems of administration. Then, too, these personality problems would be less numerous, if all persons on the staff were the best that could be obtained and if they were acceptable personally, educationally, and professionally, to other staff members.

Good people attract good people. High standards of service attract those capable of performing it. One important principle to remember, is to avoid employing anyone by reason of relationship or friendship.

Members of a professional group require that the attitude of the administration be such as to ensure a fundamental basis of relationship between the members, including fairness and justice. Many problems arise because there has not been recognition by the executive of the merit, ability, or personal qualities, of a coworker. To instill and cultivate in each staff member a sense of conscientious individual responsibility, is to contribute greatly to the soundness and effectiveness of one's administration.

If our schools are to grow, and if we are not to be hampered in our development, the aim must be that every individual on the staff be actuated by a spirit of pride in the organization, and put forth intelligent, painstaking, persistent, conscientious effort—then an ideal system of administration will have been attained.

Genuine coöperation is cordial,

energetic, individual participation in the purpose and performance of the work, and the achievement of its object. Legitimate issues should be met and decided. Problems are averted if the executive has vision to conceive, decision to determine, courage to execute. Courage is that firmness of spirit that enables one to press on against recognized odds, with firm adherence to the course of action determined upon.

Another problem met with every day is depression—discouragement over one's work or lack of accomplishment. There is an old legend which tells us that Satan was given the right to choose one influence for his own purpose, and he chose depression. This is the blighting power that crushes one's spirit—breaks the will. Such discouragement needs a wise leader who is self-reliant and who can have the patience to help the disheartened one make a thorough analysis of the situation. This builds up confidence, and growth in service will be the result for the discouraged worker. Centralization of authority is necessary in good administration, in order that time and energy be conserved, but decentralization should follow, in order that every member of the staff may have an opportunity for creative work. Accept ideas from the result of decentralization; ascertain their worth and practicability; give them due recognition; welcome all ideas. Mark Twain said: "The man with a new idea is a crank—until he has succeeded."

The fine art of an executive is to find persons in the organization who can do things better than she, and to be able to make everyone feel herself worthwhile.

Today we hear much concerning the lack of discipline in life. Discipline is as necessary in our organization, if problems are to be averted, as a rudder is to a ship, and consistent discipline is more imperatively required of an executive than of any subordinate. The best ability is reliability, and the faithful person outlasts the brilliant one, but this desirable quality springs from a disciplined nature. Morale is essential to efficiency. Problems frequently arise from wrong attitudes—misunderstood personality. Getting on well with people is a part of man's life, and nowhere as much as in hospital life is it so necessary to be courteous, to treat all with due respect. Most of our troubles in this respect are caused by acting upon feeling, not upon clear thinking.

Summing up the points mentioned, we may conclude that administrative problems come about through failure to consider properly the following problems:

Organization and administrative difficulties
Unity of purpose
Selection of properly prepared personnel
Provision for growth in service
Proper leadership
Determination of ideals
Recognition of accomplishments
Need for idealism
Practical problems involving hours, budget, environment and the many personal problems

Someone has said that the administration will have fewest problems that has, as its leader, one who thinks clearly and has the vision to perceive, the self-sacrifice and purpose necessary to do the one thing well; the pride that impels her to set a high standard and maintain it; the patience to deal with frailties that beset human nature; the pluck that presses on against all odds; the enthusiasm that keeps one above the stagnant sloughs of life; and the goodwill and concern for others that rejoice in the growth, development, and prosperity of her fellowmen.

Inhalations

Equipment Contributed by MARGARET ELIOT, R.N., HANNAH BENNER OGDEN, R.N., and D. DEAN URCH, R.N.

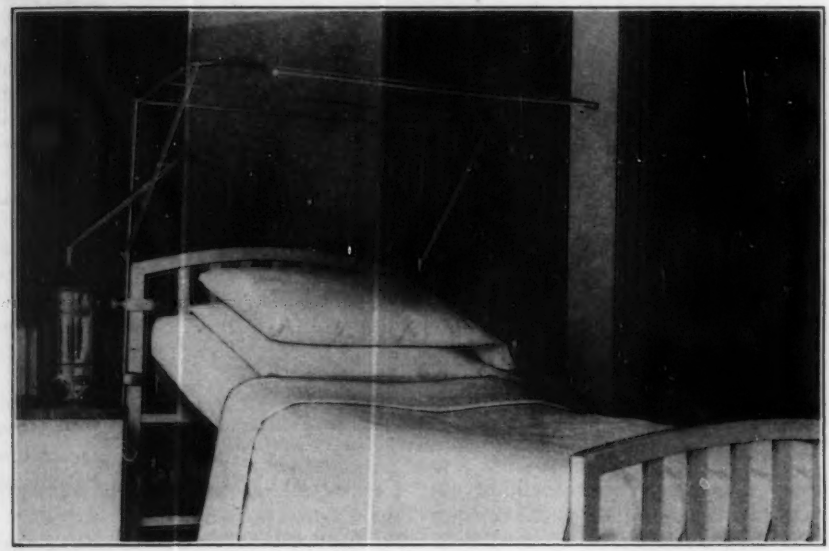


FIGURE 1.—CROUP TENT—FRAME IN PLACE

ONE of the qualifications of the good nurse, not often asked for but frequently present, is the ability to invent new equipment on occasion. The vaporizers shown here are illustrations of that quality.

Now that Gatch beds have come into rather general use, some of us have spent unprofitable hours in attempting to build a croup tent in the old way with two screens, a blanket, some sheets, and many pins —only to find after it was finished that, when the head of the bed was raised with the Gatch mechanism, the patient was brought outside of and in front of the croup tent and entirely out of reach of the steam.

One solution of that problem, and a method which is equally useful on an ordinary bed, is that shown in Figure 1 and Figure 2. It was worked out by Margaret Eliot at the Presbyterian Hospital, New York City, and though it was finally built for the hospital from her design by a surgical supply house, it is simple enough in construction to be made at home if you have succeeded in establishing rapport with the engineering staff of the hospital.

The frame of the croup tent is of light metal. The top is adjustable, and may be raised or lowered by changing the position of the diagonal bar. The whole is secured to the head of the bed by large clamps which are lined and padded with felt to keep them from injuring the enamel of the bed. When it is in place, no matter how much the head of the bed is raised, the patient remains *within* the tent.

There are two covers for the croup

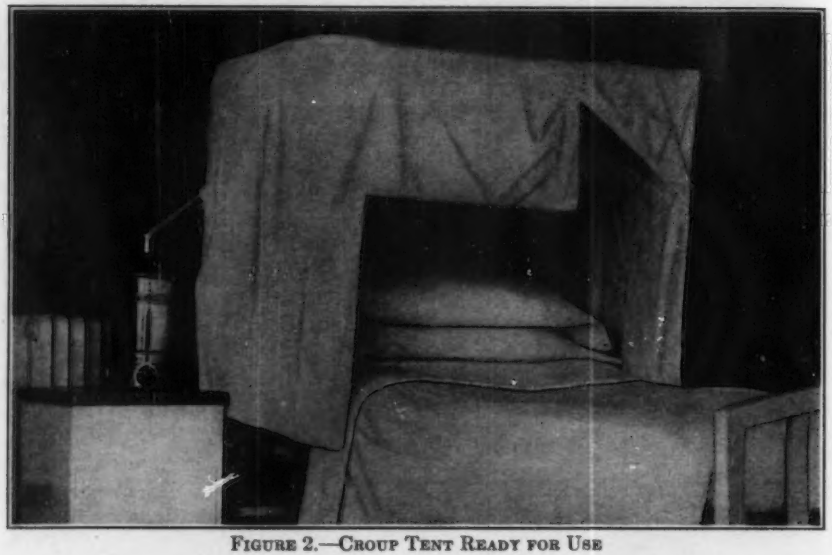


FIGURE 2.—CROUP TENT READY FOR USE

tent. The inner one is made of old wool blanket material which, because of its hygroscopic properties, absorbs the moisture and prevents it from condensing, as it would on cotton, and dropping down on the patient. The outer cover is made of muslin. Both are constructed like slip covers for furniture and are used only for the croup tent.

The croup kettle was also specially designed, its chief virtues being its height, which obviates the necessity for raising it up with books or a box, and the angle of the long spout which directs the steam toward the top of the tent and prevents the live steam from coming in contact with the patient. The kettle is made of Monel metal, is electrically run, and holds two quarts of water. It will run about three hours without boiling dry or being refilled.

The plan for the vaporizer shown in Figure 3 and Figure 4 was worked out by Hannah Benner Ogden at the Philadelphia General Hospital. It has several advantages over some of the other vaporizers.

The patient, instead of sitting up and holding it, or having the nurse hold it for him, or straining uncomfortably to reach it as it rests on the table beside him, can lie comfortably on his pillows because the funnel is long enough to reach him. The discomfort of having the warm container close to the patient's body is also avoided. The mouth piece is detachable and can be sterilized by boiling, and the opening is wide enough to cover both mouth and nose.

This vaporizer is easily made. The one illustrated is of galvanized sheet iron; the kettle is seven inches in diameter and seven inches high; the funnel—attached, ready for use—is about nineteen inches long; the opening is about four inches in diameter.

The third device (shown in Figure 5) was not invented by a nurse, but illustrates what happens when happy working relationships are built up

FIGURE 3.—A HOME-MADE INHALER

between departments. It was constructed by W. J. Rogers, Chief Engineer, Highland Hospital, Oakland, California.

The steam for the vaporizer is taken from the heating system at the radiator, *below the radiator valve*. The radiator does not have to be turned

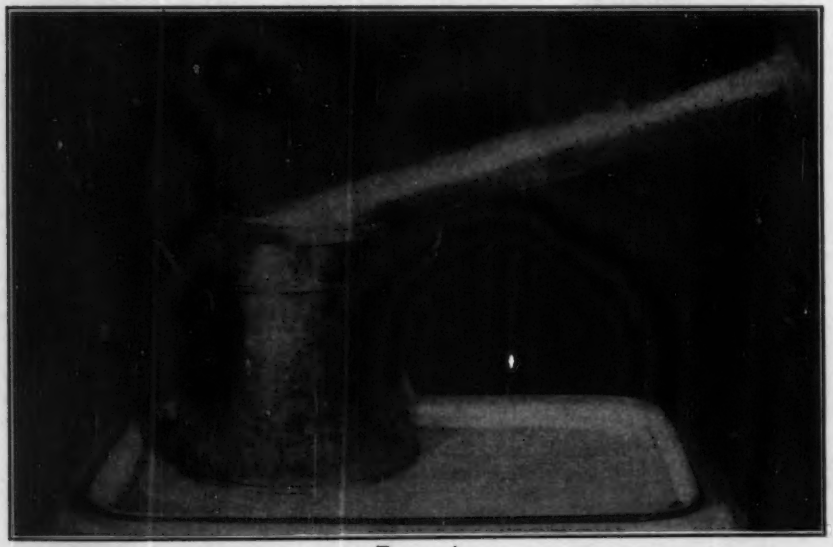


FIGURE 4

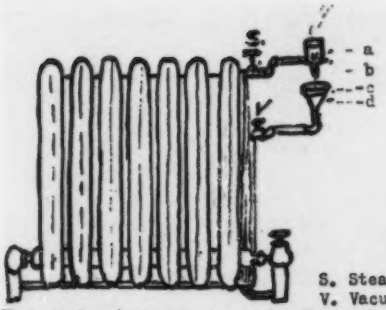


FIGURE 5.—ATTACHMENTS ON A STEAM RADIATOR TO BE USED AS A VAPORIZER[1]

on in order to use the vaporizer. The vacuum line for the removal of water of condensation is connected to the main vacuum line at the radiator below the radiator return line valve.

The extra equipment needed consists of (a) one small oil cup (⅝ inches x 2 inches), (b) a cap to serve as saucer to hold medication and supported within the (c) funnel; (d) wire gauze fitted within the funnel; and additional plumbing fixtures such as two ⅛-inch valves, two ½- to ⅛-inch T, and about 6 feet of ⅛-inch pipe.

The engineer who invented this vaporizer assures us that there is *no danger of scalding the patient.* The *Journal* also had the device checked by a heating engineer. It is necessary, of course, that the steam plant be running, as it is usually in many hospitals all the year for sterilizers and the like.

The advantages of the apparatus are that there is no danger of scalding the patient as there is with the ordinary equipment in which boiling water is used; the amount of steam can easily be regulated as desired; there is no time lost at the beginning of the process as the steam can be turned on instantly; neither apparatus nor procedure is at all intricate.

[1] A patent has been applied for.

Dried Milk as Dressing for Intestinal Fistula

IN a case of intestinal fistula developing after partial resection of the stomach for carcinoma, Rees used a dressing of whole dried milk (commercial), because it contains the elements necessary to neutralize the ferments from the pancreas and intestine; namely, proteins, carbohydrates, and fats, because it is a powder and absorbs the secretion as it is poured out, and because there is no odor from the digestion of the dried milk. The results were startling. That night the patient had his first full night's sleep, and the next morning the skin was greatly improved; long before the fistula closed, the erosions had healed and the skin had lost its tenderness. The dressing consists of a layer of dried milk, about 0.5 cm. in thickness, several layers of gauze, another layer of milk and, finally, the usual abdominal pad; it is renewed every four or six hours."—Summary in the *Journal of the American Medical Association* of August 3, 1929, of an article entitled "Dried Milk as Dressing for Intestinal Fistula," by C. E. Rees of San Diego, California, and in *Western Medicine* for June, 1929.

Activities of the Commonwealth Fund

WITH the opening of two new hospitals and the continued work of two previously established, four rural districts, one each in Tennessee, Virginia, Maine, and Kentucky, are now provided with general hospitals of their own, as a result of the Fund's activities. Additional hospitals have been opened in two more districts, in Kansas and Ohio, since the close of the year covered by the report. It is estimated that through this program some 410,000 people are enabled to enjoy near at home the safety and convenience of hospital service which in former years they had to seek at a distance or forego altogether. The objectives of this program are far wider, however, than the provision of these facilities, for these constitute only the central part of a general attempt to raise the level of rural health through stimulating the medical profession and the public in the localities, to develop practicable public health services suitably linked with the hospitals, and to foster an intelligent interest in preventive medicine.—From a release of February 26, 1930.

Federal Legislation and the American Nurses' Association

CLARA D. NOYES, R.N.

FROM time to time letters reach the boards of directors of the state associations of nurses from National Headquarters of the American Nurses' Association, asking them to approach their representatives in the Senate and House of Representatives, and urge their support of special pieces of legislation. In all probability the boards of directors are a bit puzzled by the request and wonder how it all comes about. The nurses of the country are quite familiar with state legislative bodies for have they not, since early 1900, been making pilgrimages to the state capitols in the interest of nurse practice acts, either to secure a law or an amendment to a law, or to prevent the adoption of an amendment offered by someone more concerned with some special interest than with maintaining standards?

Each state association has its legislative committee, created mainly for the purpose of watching legislation that would be injurious to the laws already in operation, or to work for amendments that would improve them. As the states have seen the need for such committees, so the national society—the American Nurses' Association— has seen the need of a similar committee to watch federal legislation.

In this case, however, nurse practice acts are not involved, but there are many measures affecting the health and welfare of women and children that concern nurses as a group, or nursing as a profession, that are constantly being presented to Congress. It is very important in some instances to see that changes are made that would improve them; in others, the assistance of the nurses of the country is required to help bring a measure to a successful conclusion. A good illustration of the former is a bill, recently introduced, asking that all women, such as stenographers and welfare workers, associated with the American Expeditionary Forces be given the same privileges of hospitalization by the Veterans' Bureau as those who were actually inducted into the military service. Red Cross nurses who were working in such places as the Service de Santé are apparently not included.

Illustrations of the second type referred to above were the measures seeking to create an Army Nurse Corps and to secure rank for nurses. It was the nurses of the country who sponsored these latter measures and who finally after a long, hard pull secured their enactment. In the former case, Red Cross nurses should by all means be included and steps should be taken to see that they are.

There are, however, many other types of legislation, in which nurses have an interest, that need to be watched; consequently a small committee of five nurses, all residing in Washington, has been appointed by the American Nurses' Association for this purpose.

The Women's Joint Congressional Committee

THE American Nurses' Association also has its representative on the Women's Joint Congressional Committee, and, in order to make as close a connection as possible, the Chairman of the American Nurses' Association Committee on Federal Legislation

serves in this capacity, with an alternate from the same committee. The Committee on Federal Legislation acts in an advisory capacity to the representative on the Women's Joint Congressional Committee. Before showing how this works, however, it is necessary to explain the Women's Joint Congressional Committee, what it is and how it functions. These questions can best be answered by quoting from a pamphlet which was recently issued by the committee:

> Soon after granting of suffrage in 1920, the Women's Joint Congressional Committee was organized. . . . It serves merely as a clearing house, endorses no legislation and proposes none, nor do all the member organizations endorse the same legislation. Whenever any piece of legislation is supported by five or more organizations, a legislative committee, composed of the representatives of the supporting organization, is formed for the promotion of that bill. The members of such legislative committees endeavor to convey to Congressmen the sentiment of constituents directly or indirectly through their members at large, and to report to the members of their organization the status of the pending measures with which they are concerned. The committee meets once a month while Congress is in session.

Eighteen national societies are included in the membership of the Women's Joint Congressional Committee, among which we find the American Nurses' Association, American Federation of Teachers, American Association of University Women, National Congress of Parents and Teachers, National Consumers' League, the National League of Women Voters, and many other equally important organizations.

Among the measures pending endorsed by constituent organizations of the Women's Joint Congressional Committee are: entrance of the United States into the World Court; the continued support and extension of the Maternity and Infancy Act; amendments to the Cabel Independent Citizenship Act to correct obvious defects; creation by Congress of a Federal Department of Education, etc.

All these measures, with the exception of the amendments to the Cabel Act, are being supported by the American Nurses' Association. It is interesting to note that five important acts of Congress have already been passed, due largely to the efforts of the organizations represented in the Women's Joint Congressional Committee. For example: provision for a Women's Bureau in the Department of Labor; the Sheppard-Towner Act; the Cabel Act; a compulsory Education Act for the District of Columbia; and provision for a federal institution for women prisoners.

Special Measures Supported by the American Nurses' Association

WHILE the American Nurses' Association is supporting the important federal measures listed above, some with international aspects such as the World Court, the organization is also supporting some special measures which affect nurses and nursing, which are not supported by a committee from the Women's Joint Congressional Committee. For example: the Joint Pay Bill—a measure which deals chiefly with the equalization of salaries paid to all those connected with the Army and Navy Nurse Corps, U. S. Public Health Service, Marine Corps, etc.; also H. R. 304, which deals with the retirement of Army and Navy nurses for disability and their pay at the time of retirement; and the so-called Parker Bill, which has to do with the reorganization of the U. S. Public Health Service. The famous Reclassification Act, which by its provision has placed certain groups of Government nurses

in the subprofessional grade, is also being constantly watched.

The American Nurses' Association has for its essential objects:

> To promote the professional and educational advancement of nurses in every proper way; . . . to elevate the standard of nursing education; to distribute relief to such nurses as may become ill, disabled or destitute; to disseminate information on the subject of nursing by publication in official periodicals or otherwise; to bring into communication with each other the various nurses and associations and federations of nurses throughout the United States of America.

Hence it is not an organization primarily concerned with measures of a strictly political nature. Therefore, it has adopted a policy that only those measures that affect nurses and nursing, or the health and welfare of women and children should be supported.

The entrance of the United States into the World Court and the Education Bill do not, strictly speaking, fall into this type of legislation. When the support of the American Nurses' Association to these measures was solicited it was felt that, inasmuch as schools of nursing were so closely connected with questions of preliminary education, it could consistently support a measure that had for its primary object the betterment of schools and educational facilities throughout the country. Although nurses and nursing were not primarily affected by the entrance of the United States into the World Court, and neither was the health and welfare of the women of this country directly involved, nevertheless, as one of the objects of the World Court is to work toward the settlement of disputes by arbitration rather than by resort to arms, indirectly the health and welfare of all women and children were after all vitally concerned.

So much for the Women's Joint Congressional Committee, and the participation by the American Nurses' Association in its privileges.

How You Can Help

WHEN a measure, such as the Jones Bill which is the successor to the Sheppard-Towner Act, becomes active, *i.e.*, when it is "in committee" and is being pushed by its supporters, a legislative committee of the Women's Joint Congressional Committee may be the group doing this pushing. Each organization represented also becomes active and its members are urged to exert as much pressure as possible upon senators and representatives, or members of the Committee. For example: If Senator Blank of Pennsylvania is chairman of a committee to which a measure supported by the American Nurses' Association has been referred, then the State Association of Pennsylvania is asked to get as many letters from constituents as possible to Senator Blank, urging his support. This is of paramount importance. While our representatives "who sit upon the Hill" are no doubt bored by letters of this type, nevertheless their absence is always noted. Apropos of this, I recall a hearing of a committee of the House on a Bill, at which time one member of the committee said:

> I cannot believe that the people of my state are particularly interested in this measure, for I have not received a single letter from any individual in my state asking me to support it.

This statement showed the importance of the letter from a constituent. For that reason, if for no other, every effort has been made to keep the state associations informed on the status as well as the purpose of various measures, and to have them in turn write to their senators or others concerned, particularly to those who

may be "lukewarm" or who are actively opposed. All these communications are prepared and mailed from National Headquarters at 370 Seventh Avenue, New York City. This is important for, although they originate with the Committee in Washington, or emanate from the representative on the Women's Joint Congressional Committee, confusion is saved by using one mailing address, and at the same time the officers of the American Nurses' Association as well as the Director and her staff at headquarters are kept informed. The Committee in Washington, composed of busy women with "jobs of their own," is not able to carry the details incident to the preparation and mailing of correspondence. As a matter of fact, the Committee meets rather infrequently. The representative of the Women's Joint Congressional Committee, having cleared with the Committee on the measure affected, attends all the meetings of the Women's Joint Congressional Committee as well as of all the Legislative Committees, of which she is a member, and prepares all the drafts of material issued by the American Nurses' Association.

It is very important that our state associations act promptly upon the matters contained in the letters of instruction. The importance of pressure from "back home" having been stressed, it may well follow that, unless everyone works, an important legislative measure, such as the Maternity and Infancy Bill, might be lost. We are glad to say that many do. A copy of a recent letter from the President of the State Association of Tennessee, relaying to the districts the information and request for support from National Headquarters of the American Nurses' Association in a most effective manner was recently seen. There have also been many others which indicate that nurses are taking their responsibilities as citizens, as well as nurses, very seriously.

It is not the purpose of this article to discuss the individual merits of the various measures which are being supported by the American Nurses' Association and for which assistance has been solicited. Copies of bills, however, can always be obtained by writing to Congress for them; furthermore, informatory material thereon has already been forwarded to the state associations. All we are attempting to do is to explain the machinery utilized by the American Nurses' Association to keep its members informed of specific types of legislation, and what steps are necessary to secure their assistance when the time seems ripe for doing so.

Many perhaps hesitate to write to the "gods who occupy the seats upon Olympus" fearing that they may not be able to express themselves in suitable language. For this reason suggestive letters have been provided. It is better for obvious reasons, however, not to send form letters. A short communication expressing interest, and urging coöperation is really all that is required. The language in which it is couched is not particularly important, as all requests from constituents seem to be noticed. Strange as it may seem, a letter from one nurse constituent, a member of a far-away District Association hitherto unknown, seems to carry more weight than a letter from the President of the national association. There are times, however, when a letter from the President is essential; for example, at a hearing a letter from the President may be presented, setting forth the reasons why the organization is supporting specific pieces of legislation, but the value even of this is doubtful

if it is not "backed up" by communications from constituents to the individual members of the Senate and House or the special committee to which the measure has been referred. The "constituent" is a most important person. We venture to say that no request, however small or unimportant, goes unnoticed or unanswered. The American Nurses' Association with its alumnae, district and state societies is particularly well adapted to legislative work. It has been a matter of real pride when telegrams have reached the Capitol from members in these branches within a few days, sometimes hours, after the first letter asking that they be sent has been received.

The longer one works with our national society—the American Nurses' Association—the more one is convinced of the soundness of the organization and the wisdom of those early leaders, who seem to have "builded better than they knew."

Rembrandt[1]

The First of the Moderns

BROOKE PETERS CHURCH

ONE is sometimes tempted to believe that the earth together with its inhabitants must form one organic entity, and like a human body may be affected in the most widely removed parts by the same stimuli, with no apparent connecting cause. Worn threadbare by the time of the Seventeenth Century, the mantle of Italian art fell, not on her neighbors France or Spain, but on far-removed Holland, who, with no visible period of apprenticeship, assumed it and carried on from where the Italians left off. Of course there were reasons for this phenomenal transference, even though at first sight they do not appear. Italy seemed to exhaust herself by her great burst of artistic frenzy. In two hundred years she produced a large proportion of the world's masterpieces of painting, attaining higher and higher levels of achievement, until she reached the apogee with Titian, Leonardo and Michael Angelo. Farther than this she she did not have the strength to go, and the followers of these men were but second rate imitators, who hid the poverty of their creative ability with cheap sentimentality or technical facility. And it was easy for them to hoodwink and charm the new and undiscriminating public that had arisen, for Italy had by now ceased even to be deeply interested, and was content to rest on the laurels of her past glories. The petty internecine wars of the Sixteenth Century had sapped her strength, and recurrent invasions by neighboring kings had destroyed even a semblance of unity. She was too much concerned with self-preservation to cultivate artistic appreciation, and for the most part too poverty-stricken to patronize great artists. The church, which had made such a brave showing in Michael Angelo's day, had now become involved in the Counter Reformation and was too busy setting her house in order to pay attention to its

[1] The third article in Mrs. Church's series on "Hidden Sources."

decorating, and none of the popes of the period stand out as great amateurs. This same Counter Reformation had roused the Catholic church to a state of religious hysteria, and turned religion into emotional channels; and in Carlo Dolci or Sassoferato, with their lachrymose Virgins and sentimental appeal, the religious world saw its repentance mirrored and was content. Spain, where art might have been expected to flourish, had Velasquez, it is true, and numerous minor painters, such as Murillo. But Velasquez seems to have been a "sport," one of those geniuses who spring up with no apparent reason at any time or place; and Murillo was frankly in the decadent Italian style. For the eyes of Spain were turned westward to new lands, and every nerve and muscle was strained toward exploiting the Americas and getting rich. No age of mere money-grubbing produces art. There was, moreover, an added drain on Spain's vitality—the Inquisition—which made self-expression, an essential quality of every real artist, a sure means of self-annihilation. By various accidents of succession Spain had become possessed of the northern lowlands, Belgium and Holland. Satisfied with religious conformity in Spain and eager to show himself a champion of the church, Charles V and later his son Philip II directed their attention to their outlying possessions. In the north Protestantism had made deep inroads on the Catholic ranks, and a reprehensible laxness and marked and growing Protestant spirit, together with an impatience of foreign domination, were evident throughout the Netherlands. For years the Spaniards strove to overcome and fetter the spirit of free thought and independence in the north, and called into service the most hideous tortures the Inquisition could devise. They only succeeded in arousing an ever fiercer determination to shake loose from Spain, and a feeling of common cause among the tiny states they persecuted. Eventually the northernmost group of these broke free and united themselves into a Dutch Republic.

The effects on a nation of a long and terrible struggle for a moral principle against overwhelming odds cannot be over-estimated. The Dutch emerged a nation tried by fire. Conscious of their rectitude and united into a cohesive mass by their singleness of purpose, they set about nation-building with the same independent and clear-sighted balance which had brought them so far; for freedom having been gained, they asked for nothing but peace and comfort. There were no great social cleavages, no great economic gaps in this little republic which was made up of substantial middle-class burghers. Much of the fighting of the war with Spain had been on the sea, and when the smoke cleared away the Dutch found themselves possessed of a fleet, and for the moment virtually masters of the sea, able to gather in the commerce of the world, while England and Spain either fought each other or traveled westward. A period of tremendous prosperity ensued. The Dutch East India Company founded colonies in the east, and its ships were the carriers of all the eastern luxuries which had come to be so essential to the western world. And at this loosening of the tension of the past struggle, and with the increased wealth and leisure, there sprang into life in Holland a full grown school of art.

There are no Dutch primitives. Any earlier painters of the country were either frankly Italian or Flemish in feeling and technic, and founded no schools, left no followers, and made

no innovations. There was no preparation and no presentiment of the great artistic flowering that followed the revolt of the Netherlands. Out of the loins of the patriots of Holland there came unheralded a new race of painters—men imbued from birth with a love of their hardly-won little land and eager to express this love in endless picturing of their prized possession. In a Calvinistic country, where churches were bare of images and pictures—in a northern country, where great wall spaces were scarce, owing to the need of many windows to let in the scant light—fresco painting and immense canvases of religious subjects, such as the Italians loved, were not only out of place, but impossible. A new style of art was necessary. And the Dutch found it; they painted portraits—portraits of their beloved Holland in every aspect, of her countryside, her life, her homes, her people, even her utensils. They imagined nothing and left nothing to the imagination, but painted the world about them as they saw it, with all its homely details included with loving care. Most of the pictures were small, intimate cross sections of every-day life, for they painted not for rich patrons, but for comfortable burghers, who were flattered with the meticulous representation of what was familiar to them. In the seventy years more or less of this artistic activity, over a hundred great genre painters flourished in the newly created little republic. But art was only one expression of Dutch progressiveness at this time. They had a new country to make, and with the industry and exactness of ants they worked at their task. They founded universities and libraries, erected public buildings and churches, collected art treasures and curiosities from every region and time, even to the extent of bringing in wild animals to form menageries; they organized charities and corporations, and formed guilds for the protection of the trades. They were as scrupulously honest as they were scrupulously clean, and as matter-of-fact as they were balanced in judgment. The new cities that rose on the ruins of the old were not beautiful except for their suitableness. They were meant to live in peacefully, and were light and airy, with monotonous rows of identical houses, bare churches, dignified but plain public buildings and active and important commercial or docking sections, where sober-suited men transacted world-wide business.

The Youth of Holland's Most Famous Son

THE most beautiful city in Holland was Leyden, where the intellectual center of the country, and in some degree of the world, might be placed in the great university. Above the great dykes which protected it from the sea moved the sails of passing ships, which seemed to float above the house tops; rich pasture lands spread inland, and everywhere the busy waving arms of windmills showed against the skyline. Near one of these, there was born in about 1606 the most famous citizen Holland ever had—Rembrandt. His father was Harmen Gerritsz, a well-to-do miller of the middle class, but rising in the world. The son was accordingly Rembrandt Harmensz, but he later took the name by which he is known today, van Ryn (of the Rhine). His mother was one of the great influences in Rembrandt's life. He painted many portraits of her, and had always a special fondness and aptitude for painting old women, especially old women reading the Bible, or pondering what they have just read. She was a simple, quiet, and

affectionate woman, deeply spiritual and devoted to the Bible and its teachings. Rembrandt never tired of illustrating Bible stories and himself became increasingly interested in their rare dramatic quality. The influence of his early years made itself felt in other ways as well. There was opportunity for wide intellectual contacts in Leyden, for the University drew to it thinkers from every land, and the kindly tolerance of Holland kept them there. Rembrandt was prepared for the University, but showed so marked a distaste for intellectual pursuits that his father finally agreed to let him study art instead. But there is no doubt that some of the culture in which he lived affected him, for his work displays an intellectual quality and a depth of vision which presuppose a cultural background. For three years he studied in Leyden and then went to Amsterdam, where he worked for six months. Amsterdam was the greatest commercial city of the world at the time. Here the great East Indiamen docked, and the mysterious lascars unloaded strange cargoes on the swarming docks. There were bales of silk, great cases of sweet-smelling spices and perfumes, idols grotesquely carved for curious faiths, teakwood and ivory. The whole world seemed to spread its choicest wares on the docks of Amsterdam, where boys could ramble about and drink in the flavor of distant lands and dream of the exotic East. Some of the most impressionable months of Rembrandt's life were spent in this atmosphere and, though he never traveled, his years of observation provided a store house on which he drew for the imaginary world he so often put into his pictures.

These three and a half years seem to have been the only artistic training he ever had, for in 1627 he came back to his family in Leyden and thenceforth was his own master. But the schooling which he gave himself was severe and never stopped to the end of his life. His family were pressed into service as models, even his friends, and we meet them again and again on the canvases of this period, sometimes in their own quiet clothes, but more often in ornate costumes made up of the properties which he was beginning to accumulate. He seems to have been of a singularly lovable and open nature, and yet he was by preference a hermit. Generous to a fault in material respects, he was avaricious of the time and the privacy essential to his work, which was absorbing him more and more.

The Dutch were not slow to recognize talent, and before long Rembrandt began to receive important commissions for portraits. Many of these came from Amsterdam, and in 1631 Rembrandt finally left home and settled there permanently. This was the extent of his travels—Leyden and Amsterdam and their environs. But into his pictures Rembrandt painted a world created from the flotsam and jetsam of what he heard and saw about him. Holland was a rather drab country for the most part. Her citizens were richly but soberly clad, her women buxom and rosy or stout and matronly. About her there was none of the gaiety and sensuous enjoyment of Italy. To be sure there were occasional drinking parties, or the peasants might grow too noisy or go to excesses at a kermess. But of the subtle pleasures of France and Italy, the sights and sounds and odors prepared to appeal to the senses, they knew nothing. Life to them was comfortable but serious, and yet Rembrandt has put into it a quality of romance that no other painter ever

found, the basic romance of living between two eternities, of which most of the world is unconscious.

Rembrandt's Happiest Years

IT was in Amsterdam that he met and married Saskia. For the human side was strongly developed in Rembrandt. Leonardo lived and died in utter loneliness; Michael Angelo scorned with fury all the bonds of family life; but to Rembrandt such ties were essential, and it was inevitable that, shortly after leaving the home of his boyhood, he should set up a home of his own. Now he entered upon the happiest years of his life. There was plenty of money, for Saskia had a modest fortune and Rembrandt, at this time the popular painter of Holland, was crowded with orders. The amount of his work was always prodigious, for besides the portraits and groups which he produced for the burghers and guilds, he painted numberless studies apparently for his own pleasure and in answer to an inward driving force, and in addition etched and drew, sometimes hurriedly to jot down an idea or a pose, sometimes in his finished manner, which has no equal. He made portraits of Saskia and of himself, which show us an intimate side of their own happy life. Rembrandt looks out of the pictures an attractive young man, with an open friendly expression, merry eyes, and the air and pose of a courtier. Money poured in on the young pair, and as rapidly poured out again. The artist had a flair for collecting curios and beautiful rarities, and his house was crowded with pictures, statuary, armor, oriental robes, gorgeous hangings, until there was scarcely room left for the typical Dutch housewife's linens and copper. Saskia was decked in furs and velvets and jewels, which look somewhat out of place in setting off her pleasant but round and placid face. He bought a large house, for which he paid half down; the other half was never paid, nor was the interest, nor even the taxes, for though there were many large sums in his hands, he always spent them on something else. He worked unceasingly, painting or sketching everything that came to hand. Models were hard to procure in Holland, especially models for the nude. The people were too straight-laced and self-respecting to lend themselves for such unseemly purposes. To have one's portrait painted in dignified pose and garb was one thing, to sit in fancy dress or in no dress at all for a painter's fancy, was another. And yet to increase his knowledge and perfect his art Rembrandt required models who would comply with every demand, appear in any array. He used Saskia as often as he could, but for the sake of his art he often went farther afield, and many of his pictures show us figures of an almost offensive ugliness, painted still with the care and loving detail which he gave to every subject he undertook. During this period Rembrandt's genius began to assert itself and appear as different from that of his fellow artists, and it was the culmination of his financial and artistic indifference to the world that finally ruined him. In his early years he was not so unlike his contemporaries as to cause comment, except for the excellence of his work. He painted prosperous, open-faced burghers and their kindly, corpulent wives, or groups of responsible business men at work. Here and there as the fancy struck him he would illustrate a Bible story, choosing chiefly those from the Old Testament or the Apocrypha and, though there were men who appreciated and bought and even ordered more of these pictures,

such men were few and most people in this land of portraits looked askance at such erratic tastes. Moreover, his treatment of the subjects was not at all in keeping with the tradition, and the lovers of Italian art in particular were put off by Rembrandt's departure from convention. For in these Bible stories he portrayed men and women as they actually were, and so made homely and universal these sacred subjects, bringing them within the ken of every man. In spite of carping critics he went farther and farther into the path he had chosen—farther and farther afield from his predecessors. He was working out the treatment of light and shadow, a problem which had absorbed Leonardo, and which in the end became the outstanding feature of Rembrandt's art. To bring the atmosphere into his pictures, and to explain by means of light—these were his aims. Outlines and definite color divisions merge, and more and more his subjects seem to swim in the air about them, to take on reality. A new depth and sympathy creep into his pictures of this period also, possibly because of the man's own grief brought on by the knowledge that Saskia was dying.

The Tragedy of the Artist's Later Years

THE inevitable came. Saskia died, leaving Rembrandt a heart-broken widower with a little son to bring up. In the settlements that followed, the state of his money affairs was revealed. He was in debt to an alarming degree and, as if that were not trouble enough, suddenly his popularity began to wane. It was customary at the time for a guild or corporation to have pictures of its most prominent members painted to hang in the guild hall. These pictures were paid for by the various sitters in proportion to their importance and the size of the picture. To Rembrandt was given a commission to paint such a group of men, and the "Night Watch" is the result. The picture, while one of the most famous, is not by any means the finest of Rembrandt's achievements, and at the time brought a torrent of abuse on the artist's head. It was so unconventional in its treatment of the subject, and so incomprehensible to its audience, that it turned from Rembrandt many of his patrons and noticeably lessened his popularity. Conventional, conservative and careful citizens did not care to trust their portraits to so unaccountable an artist. And so, in a period of financial embarrassment, Rembrandt found his source of income lessened. Hampered by money matters and by the care of a sickly child, it is hardly to be wondered at that he presently shocked his staid Dutch neighbors still more, by becoming involved in a liaison with Hendrickje Stoffels, the nurse of his son, Titus. But this entanglement was what saved Rembrandt in the end. Hendrickje made the home that he found necessary, took care of Titus and of the little girl born to her and Rembrandt with equal affection, acted as model, and stood between the artist and his creditors. When, a few years after Saskia's death, Rembrandt was sold up and left homeless, and—what was worse—deprived of his art treasures, Hendrickje's common sense and shrewd native ability salvaged enough from the ruin to establish the little group in a poor but adequate home, where Rembrandt could continue his work. As always he was his own best model, and we see him at this period old and lined, his body heavy, and his clothes not the ornate trappings of his youth, but an old smock and a dirty nightcap. Yet the same pene-

trating eyes, the same kindly smile lurking about his expression, show us that essentially the artist had not changed. He was still searching for truth, the inward truth of the landscape or the face or the gesture he was painting. In the Metropolitan Museum of Art in New York there hangs a picture of an old woman cutting her nails. It is a homely scene, an intensely mundane occupation. But there radiates from the picture a glow of more than mere light. In that homely act performed by a time-worn old woman, one feels the appeal of age, the pathos of the spirit hampered by the body it is soon to leave, and despite its preoccupation with other things, obliged to attend to the body's daily wants. All of old age, in its beauty, its serenity, its lovely memories, its problematic future and its kindly wisdom, born of patient experience, is set before us in the golden glow of the master's great picture. And yet he says none of this, but leaves it to us to find. He was the first of the modernists, one might even say (using the modern patter) the first of the impressionists, trying to communicate abstract ideas by expressing the truth as he sees it. He saw eternal truths in every-day facts, and because he saw and felt them and so inevitably put them into his pictures, he was misunderstood by a matter-of-fact generation, and forgotten and passed over even in his lifetime. His last great masterpiece, the Syndics, into which he put with the ease and skill of perfection all that he had learned in his lifetime of study, was given to the world without arousing a comment. He had gone too far for his age to follow him, and from this time on he sank deeper and deeper into oblivion. At the last he was left quite alone, for both Hendrickje and Titus died, and Rembrandt dragged out the last two years of his life in abject poverty. The only mention of his death is in the parish register of his district of the year 1669. By the irony of fortune he is today the one painter who appeals to every one—whether modernistic, classic or romantic. All can find in his gigantic remains something which they understand. Dutch to the core, provincial in his experience, ignorant of the humanities, self-taught, he yet has passed beyond the limits of time and place, and by his genius created a new world where all may meet and, in understanding him, understand life and so each other.

It is hard to find interesting books on Rembrandt or on his period, for it is a period of very little outward color, though it can be illuminated by the imagination until it has a rare glow of romance. For the general history of the art of the time, Faure's *History of Art*, Vol. IV, W. Bode's *Great Masters of Dutch and Flemish Painting*, and Fromentin's *The Old Masters of Belgium and Holland* are both helpful and interesting. There is a short life of Rembrandt by Baldwin Brown, and a long one by Michel. But the way to study Rembrandt is from the actual pictures he painted, and fortunately these are so numerous and so widely distributed that America contains several, scattered from coast to coast in the art galleries of the large cities. The best way to study them is to look at them again and again, with special attention to the eyes and mouths of the portraits. No one will need to show you what to look for. Inevitably you will come to feel the power and force of the painter who created these people.

A Time-Saving Device for Hot Compresses

MARJORIE HAYNES, R.N.

ELECTRIC PLATE SOLDERED TO METAL TOP TABLE AND WHEELED TO THE BEDSIDE WHEN NEEDED

THE equipment described here provides a quick, simple, and efficient method of applying hot stupes or compresses. It is home-made and consists of:

1. One table with metal top, length 22″, width 22″, height 30″, equipped with casters.
2. One electric plate with cord and attachment.

The electric plate is soldered to the table to eliminate any danger of its slipping off. This also prevents the plate from being mislaid or put away in some forgotten place between treatments. The table is large enough to allow plenty of room for the rest of the equipment necessary for the procedure. Since it is fitted with casters it may easily be moved to any bed side in the ward.

Field Trips

JENNIE C. QUIMBY, R.N.

CLASSES in training at the School for Nurses of the Tennessee Coal, Iron and Railroad Company Employees' Hospital, Fairfield, Alabama, enjoy special advantages in the way of field visits which are found to be of exceptional value in stimulating interest in particular subjects, and in providing first-hand information concerning some of the modern processes used in safeguarding health.

The hospital is situated in the Birmingham industrial district and is the base of the Health Department of the Tennessee Coal, Iron and Railroad Company, which looks after the welfare of approximately 30,000 employees and their families. An annual survey is made by the company to ascertain the health habits of its employees, with the purpose of correcting habits not conducive to health. Besides the twenty-two grade schools operated by the company, where children are given annual physical examinations, with follow-up treatment by visiting nurses for those found to be defective, children's clinics are held in nine villages, under the supervision of a chief pediatrician and three assistants. Clinics for the colored children are held separately from the white.

Owing to ample facilities for transportation, student nurses at the hospital are afforded opportunities of participating in the wide range of activities and interests of the Health Department, and certain classes are taken to visit industrial plants in the neighborhood, where up-to-date methods in actual use may be observed. The following outline will indicate the nature and value of the information gleaned, with its relation to the studies of the class.

The Sanitation and Dietetics classes were permitted to visit a pasteurization plant, a certified milk dairy, a dairy using electrical milkers, an ice cream plant, a bakery, and food markets in daily operation.

At the pasteurization plant, a "grade A" concern under municipal regulation, the class was shown the milk in large tin cans as received from dairies of all grades. Then the process of making the milk safe for consumption was demonstrated and explained as pasteurization. The students were shown how bottles and cans were cleaned and sterilized by steam, and the entire bottling process accomplished by machinery, free from contact with hands.

The visit to the certified milk dairy occurred at the afternoon milking hour. Here it was explained how milk could become contaminated, however pure it might have been at first, and measures for preventing contamination were emphasized. The cows were in a stable especially built and equipped to carry out hygienic measures, and the employees, clean, dressed in white, were required to wash their hands frequently. The udders of the cows were washed thoroughly and, although it was winter time and the water cold, they seemed to enjoy it. The manner of bottling was similar to the method in use at the pasteurization plant. For a period of more than three years the company operating this dairy has not had a bacterial count as high as 10,000 per cc. (City Health Department records). This count is low compared with the requirements of health departments of other cities of similar size—a fact worthy of notice by nurses interested in public health. At another dairy,

where cleanliness prevailed throughout as in the other types, electrical milkers were shown in use.

The ice cream plant, municipally regulated, used milk and cream provided by the pure milk dairies only. Its machinery was up to date and the plant throughout shown to be as clean as possible.

The bakery was also municipally regulated. Here was demonstrated the method of making and handling an immense amount of bread, resulting in a clean, wholesome product. The bread is mixed, weighed, baked, and wrapped without touch of human hands.

The visit to the markets was invaluable in teaching how food should be examined before purchase, the method of buying in large quantities, and the need of discrimination in buying foods for immediate consumption or for future use.

The class in Sanitation visited the municipal water works, a biological sewage disposal plant, a large commissary, a stable where the fly nuisance is controlled by sanitary measures, and a mosquito-controlled lake. At the water works the students saw huge reservoirs receiving water direct from its source, and learned how the water underwent a process of purification in filtration tanks before it was piped to the consumers in the city. The biological sewage disposal plant, besides demonstrating methods of sewage disposal, showed how to prevent contamination of other agents.

The commissary showed evidence of fly control by adequate screening and cleanliness, even where food is handled in large quantities. In addition to screened doors, windows, and other openings in the building, all food easily contaminated was kept in particularly screened enclosures.

Although it was a mule stable that the class visited, it was found to be much cleaner than some cow stables. Clean food for the animals, and twice-a-day cleansing of stalls, with all excretions treated to make them free from flies and safe as fertilizing material, proved what could be accomplished in the effort toward fly control.

The visit to a lake whose water is used for power, and where operators spray the surface with oil, daily, showed how the mosquito pest may be controlled until it is a thing of the past.

The classes also visited iron mines, where the crude ore was seen loaded into cars, and a visit to the mills showed the ore transformed into useful materials, such as rails and bolts.

In addition to these visits, lectures are given to the entire school on the control of communicable diseases, and educational films are provided to show what may be done to prevent malaria, diphtheria, hookworm disease, etc.

The phases of professional training mentioned herein result in a clearer conception of the subjects under study, and their application to hygienic living. The success of the field visits is attested by the eagerness with which the classes look forward to them each year, and by the vivid interest manifested in the demonstrations.

Medical Service for the Child in Prenatal and Maternal Care

THE greatest asset of a race is its children; that their bodily strength and development should prepare them to receive the heritage which each generation must bequeath to the next. These questions have the widest of social importance, that reaches to the roots of social democracy itself. By the safeguard of health and protection of childhood, we further contribute to that equality of opportunity which is the unique basis of American civilization.—President Hoover at the White House Conference.

The Nurse and the Public

IV—Ways and Means in Public Information

VIRGINIA McCORMICK

THERE are many ways of telling the story of nursing and many media through which that story can be told. First and foremost, of course, comes the newspaper, concerning the use of which there was an article in the March issue of the *Journal*. For the dissemination of news, it has no rival in contemporary life.

But for public information there is also that great array of printed matter which pours from the presses and through the mails of the country, magazines, pamphlets, form letters, bulletins, a dizzying procession of words on a vast variety of subjects.

Then there is that effective means of telling the public through pictures, by using exhibits, posters, motion pictures, and window displays. And that the public can be reached through its aural faculties has been proved frequently through that popular device, the radio. The same principle applies, in modest ratio, to talks to the laity on nursing subjects.

You have, then, a half dozen types of organs through which to disseminate public information on nursing subjects. And, though the technics vary and the methods of presentation differ, the same principles are to be observed no matter what form the publicity takes.

The Great Commandment

Every written word, every spoken phrase, every line of a drawing, must be calculated to reach and to hold the attention of the public because it is of interest or importance *to the public.*

THIS great commandment in nursing publicity is an exact parallel to the impelling motive underlying all nursing. The patient comes first always and unalterably for the real nurse. The reader comes first always and inevitably in planning public information.

Hospitals may be faced with staff shortages. A third of the student body may have influenza. Cooks may leave and maids be undiscoverable. It does not matter. The patients must be nursed. The patients must be comfortable. And the patients are not interested in administration problems, problems of extra hours and added labor and weight of perplexities for the staff that are of secondary consideration with it also. First comes the patient.

So in public information. There may be a dozen matters discussed at a state meeting which are of real importance to the nurse, none of which, however, is of the least interest to the newspaper or magazine reader, or to the listener-in on the radio, because they deal only with professional details and do not directly concern him.

In a magazine or newspaper story, bear in mind, moreover, the type of readers of that periodical and use your material accordingly. A story that would be of real interest to the readers of the *Ladies' Home Journal* would not be suitable at all for the readers of the *American Mercury*. The same material may go into the building of an article for *Harper's* and for a story in the *Red Book*, but the presentation will be very different.

The material used in posters should be, not the important fact from the professional angle, but the one salient point of concern to those who see that poster and either give it a glance

THE NURSE, IN HER PRIVATE AUTOMOBILE, SPEEDS TO THE PATIENT'S ADDRESS PREPARED TO STAY FROM FIFTEEN MINUTES TO THREE HOURS

and pass it by, or stop for a closer look because it has caught their attention. Note, for instance, the 1930 membership poster of the American Red Cross. The nurse is the center of the picture. Yes. But it is the nurse holding close to her a ragged small boy. When he came into the picture, the popular appeal entered also, because the nurse was shown doing something for someone—and childhood, more than anything else, will catch the eye and hold the heart.

Above all, in giving radio talks, keep before your mind's eye a group of listeners-in and talk to them. If, let us say, you are broadcasting in the evening, address yourself to a family group. Picture the father half listening while he reads the evening paper, the mother resting a bit after finishing her work, daughter giving her undivided attention to the radio as she turns the dial. Will she stop to listen to you, or will she move her hand to reach out for some music?

If you actually see these people before you as you prepare your radio talk, you will find that it will be quite different in tone from your ordinary speech. Notice this introduction to a radio talk given over WEAF by Janet M. Geister, R.N., Headquarters Director of the American Nurses' Association:

> I want to talk to you about what to do when you need a nurse. If an emergency arose in your family today, where would you find a nurse? How would you know that you were getting a graduate nurse, one to whom you could entrust the life and death responsibility of caring for your loved one in his illness?

Following this introduction there were simple descriptions of the hospital, the official registry, various types of nursing care, the significance of the nurse's registration.

The Second Commandment

THE second commandment in nursing publicity is equally brief, equally obvious, and equally vital; namely, *Be accurate.*

Once you have caught the attention of the reader or the listener-in, you must give him what he has the right to read or to hear, facts, clearly presented and simply stated; facts that are not misrepresented through careless wording, not misstated through slipshod work. Accuracy is the beginning and the ending of all forms of public information. There may be a half dozen ways of writing a story on hourly nursing. But in every case the facts presented are unalterable. The poster may show the nurse doing any one of her various duties, but the presentation must be correct in detail.

Inaccuracy is a "lion in the way" of public information. It may be the result of carelessness. It may result from lack of information on the part

of the person responsible for issuing the material, or on the part of the person doing the work. But whatever the cause, an inaccurate account or statement will counteract entirely any good which might have been derived from a story.

Accuracy begins at home. The nurse collecting the material for a newspaper story or for a folder is the person whom it behooves to be accurate. The reporter, or the writer engaged to put the leaflet material into readable form, will take what is given him and use it. Nor can you assume that he knows anything about nursing except those facts which you have given him, for he will consider the material as authentic because it has come from an authorized source of nursing publicity, and he will use it accordingly.

You may have noted already the illustration on the opposite page. The hourly nurse, you will agree, does look a bit odd, dashing about in a car, with a fur coat over her white uniform, a white cap perched over her curls. Now, the artist probably was given the full credit for the error in presentation. Perhaps it was his fault. But if the nurses who gave the story to the newspaper knew there was to be an illustration, the real responsibility rested there. A few words describing the uniform of an hourly nurse would have helped the artist, would have avoided misrepresentation in the drawing, and would have been much appreciated. To the average layman, it is surmised, a nurse's uniform of one kind is just the same as another until the differences are explained.

Quite different from the standpoint of accuracy is the diminutive young woman with her back to you on this page. She, too, is going out-of-doors in wintry weather. But note the correct details in dress—the coat, hat, bag, and the grand old-fashioned overshoes, perfectly clear even in the small cut. If Mr. Layman saw her original on the street, he would say, "Oh, there goes one of those nurses I was reading about." But alas for the young lady with the curls. She already has entered oblivion because her perky white cap never will be seen on the city street.

Thus it will be seen that absolute accuracy in details is essential if public information is to have its full value and fulfill its function, accuracy in subject matter, in names of persons, dates of events, information of any kind.

Keeping These Commandments Obliterates Obstacles

APPLY these two principles to various forms of publicity and see how many of your problems fade into oblivion. Assembling material for speech or leaflet, for radio talk or to give to a newspaper reporter, often seems more difficult than it is because the nurse is faced with a mass of material and does not know what items to select for her story. But if she takes only that which is directly pertinent for the possible patient, she will find the matter of selection a relatively simple one.

If, for example, you are preparing a folder on community nursing assets, you will plan first to use only those facts concerning your nursing services which are important for the possible purchaser of that nursing service. You will tell him (a) what types of nursing care he can receive; (b) where he can go to get this care; (c) how much it will cost him. If you are careful and thorough, you will collect

all this necessary information, and, in striving for accuracy you will find that you are presenting these facts in the simplest and clearest of terms.

Suppose it is a window display that you are preparing for your local hospital. Do not show merely a pretty wax lady in nurse's uniform. The public is interested in nurses. But first of all it is interested in the public. Show the nurse doing something for a patient. Or make a doll-size model of one of your wards or one of your technics with the nurse and the patient both prominently placed. The few words that you will need in explanation will be directed to the passer-by, so that he will stop and look, and having looked, will remember.

Two Don'ts

TO these two major rules in all public information, there may be added two warnings. The first is, *Do not crowd your material.* The second, *Do not preach.* If you strive for accuracy in what you are writing or in the material you are collecting for a leaflet or bulletin, and if you reduce your material so that your single purpose is clearly evident, you will find that the sentences form themselves in simple, readable form.

The tendency to use a great many words is common in the nursing profession, but certainly it is not confined to that group. It is often due, we suspect, to the fact that the writer or speaker is not quite clear in his own mind of what he wants to say, but he does have an ear for words and enjoys the sound of them—or the sight. He may know his subject in a general way, but he has not reduced his material to simple fundamental statements first of all.

We are speaking, of course, only of such writing or speaking as is involved in public information. Nor do we mean that this material should be used in blunt or unembellished style. But if, first of all, you simplify what you want to say until it has been condensed to a few key phrases, you can develop it lucidly and simply without sacrificing your individual style.

This method will tend to eliminate the overcrowding of the article with material. So many stories contain much more information than the reader will absorb. So many form letters are a mass of inked lines with narrow margins and single spacing. So many pamphlets fairly bulge with facts, a half dozen items in every paragraph.

The booklet most easily read is that with wide margins, spacing between paragraphs, a decoration or two—and the information reduced to those facts which are indispensable for the reader. One could write a voluminous tome about the care of chronics. But the registry that wishes to tell the chronics of the community about the availability of its hourly nursing service, needs to incorporate in the folder it is preparing only three or four briefly stated facts. Remind the chronic and his family that he may need a certain minimum amount of skilled nursing care. Win his confidence by defining the official registry. Tell him how the registry is prepared to give that care. State hours and prices. If there is space, give a paragraph to other registry facilities. And that is all.

The tendency to overcrowd is particularly marked in the use of posters. Against the advice of the artist, nurses time and again insist on giving statistics, or advice, or considerable information on posters, and inevitably their chief value is lost as the primary meaning is obscured. The principle of stripping information of all but its essentials as they are

related to the public, and then of presenting these essentials in attractive form, is most important in posters, exhibits, and window displays.

Pick out the one fact or two that are of real significance to the lay group you are reaching, the message you wish to convey to the public. Then picture this fact vividly, word your message succinctly, and let it go at that. Did you notice the wording on the Red Cross poster already referred to? No statistics. No specific accomplishments. Merely the words, *Yesterday, Today, Always, The Greatest Mother,* and in the upper corner, the imperative, *Join.*

The warning against pointing a moral may seem extraneous. But it is a tendency among the speaking and writing groups of nurses, which they share with similar groups in various other professions, to insert a bit of moral, or to make editorial comment on their material. Unless you are writing a magazine article or making a speech, the subject of which is interpretive rather than factual, avoid editorial comment as you would poison. What you, as an individual, think, does not matter in that story. Let the facts speak for themselves. They will. Let the reader draw his own conclusions. His interest in the subject will be greater, and the results in public information will be sounder and more helpful.

Applying the Principles

NOW apply these principles to the varied media for public information that we have today, and you will find the same fundamentals in every case, the essential need for care, promptness, and precision, and for centering the interest in the reader rather than in the writer or the subject.

Magazines and Newspapers

THE newspaper is the greatest single organ for public information. Many magazines and periodicals also will use stories on those aspects of nursing which are pertinent and of interest to their public. In using newspapers and magazines

1. Reduce your material to the few essential points of interest to the reader.
2. Develop these facts only with such stories and details as will emphasize and illustrate your principal points, so that the primary purpose always is in the foreground. Do not overcrowd with material. Do not moralize.
3. Unless you are accustomed to writing, it is best to give your material to a newspaper reporter or magazine staff writer to handle for you.
4. Be absolutely accurate in facts presented, in names, dates, details.
5. Always observe editorial rules regarding closing dates, etc.

Speeches and Radio Talks

NURSES are quite accustomed to speaking to members of their own and kindred professions. The time has come, however, when there is a need to tell the story of nursing to lay groups also, because the public has the right to be informed on nursing subjects. Radio talks on nursing are certain to find an audience. But the technic of radio talks is particularly difficult because they must hold the attention of a restless audience and must, therefore, be of interest to the public in every sentence, every fact, and every illustration of that fact. In these forms of public information

1. Make your talk very clear, very simple.
2. Remember that your hearer is listening because he wants to be informed. Tell him what he is interested in hearing, not what seems important from the professional angle to you.
3. Reduce your material to one or two major facts or ideas which you wish your hearers to remember. Develop these facts

with illustrations. Nursing is full to the brim with stories to hold an audience, to make the hearers laugh and cry and help them to remember.

4. If you talk simply and clearly on the platform, reduce this to even simpler, clearer terms in radio talks because your audience represents a wider social range. Word your talk and choose your stories so that they will be understood equally by the janitor's wife and the retired bank president.

5. Do not confuse your main points with many statistics or a recitation of a number of facts. Be brief. *No soul was ever saved after the first twenty minutes.*

Bulletins, Leaflets, Form Letters

THERE are many forms that can be used for disseminating information on a specific subject, folders and leaflets, bulletins and form letters, handbills and broadsides and booklets. Of these, the most helpful in nursing publicity probably are the bulletin, the folder or leaflet, and the form letter. Handbills or broadsides are too spectacular to be useful in public information on nursing subjects. Booklets are used only, ordinarily, where an elaborate (and expensive) explanation is desired. They are extremely valuable as a means for presenting annual reports in a readable form. In using these media for public information

1. Be brief. Brevity is the keynote in compiling folders, leaflets, bulletins, form letters, etc.

2. The fewer the words, the more carefully they must be chosen. Select simple, vivid phrases.

3. Strive for uncrowded, easily read pages.

4. Choose varied type faces and use attractive forms for leaflets and bulletins. Colored paper and line drawings add to the interest.

5. Word form letters as if directed especially to the individual addressed. Leaflets also may have the personal emphasis. But bulletins and booklets should be so written that they can be excerpted or copied without alteration by newspapers and periodicals.

Pictures, Cuts, Posters

A PICTURE helps to attract attention to a newspaper story. A little art work goes a long way to add to the readable appearance of a story or leaflet. Even mimeographed form letters can be embellished a little. In the use of art work

1. If you are asked for your picture by a periodical or by a nurse doing publicity for her group, do not send the only photograph you have. Get the photographer to make you a glossy print. Write your name, address, and the position you hold, clearly on the back of the print.

2. The same principle is true if you are arranging for pictures. Ask for glossy prints, and be sure that they are marked clearly before giving them to newspaper or magazine.

3. An illustration or decoration adds to the interest of folders, bulletins, and stories. Annual reports in booklet form and descriptive articles should have pictures, usually photographs of places, people, and work. Drawings cost considerably, but often, if the budget is limited, you can find an art student to make a sketch or two at little cost, and often printers can find cuts hidden away in their files that will do for decorative purposes.

4. Posters should be simple and striking. A single figure or group should be used and only a small amount of lettering. Select the keynote of interest for your public and use that. In the lettering, address the reader directly, or word the message to appeal to the layman.

5. Posters are used only for special occasions and purposes, and always, therefore, in conjunction with other forms of public information. Let the newspaper article, the leaflet and the radio talk tell the story. Use the poster only as a visual reminder.

Window Displays and Exhibits

OPPORTUNITIES are increasing constantly for giving information on nursing subjects through exhibits and displays at conventions, in show windows during health weeks or hospital drives, and at fairs and expositions of various kinds. In telling the story of nursing through this means

1. Accuracy of detail is absolutely vital to an exhibit or window display. Approved comment was excited in a ward exhibit, we remember, by two pen holders on the desk, one black, one red, each of them perhaps a half inch in size.

2. But even to achieve accuracy, do not overcrowd. Even when making a miniature ward or showing with four-inch dolls a nursing technic, strive for spaciousness. Otherwise you will tire the eyes, and in trying to absorb the details, those who view the exhibit will fail to grasp its primary purpose.

3. Bear in mind always the point of view of the public. Ask yourself what there is in your subject that can be made into an exhibit of compelling interest to the layman. The historical wards of Bellevue Hospital, shown at Atlantic City and Montreal in 1929, were of real interest because of their historical accuracy. But, taken with the modern hospital wards, also exhibited, they made a direct appeal to the layman, because he was able to picture the vivid contrast and to see how much better care he can receive at his hospital today than could his ancestors a hundred years ago.

4. Give local interest to an exhibit. A window display that attracted a large crowd showed a small nurse doll in a small toy automobile, circling round and round a miniature town after the fashion of toy machines. But the streets were marked with familiar names and the crowd was amused to see the nurse stop at a house, first on one familiar street, then another. A single sign in the window told what hourly nursing is, and where it could be procured in that city.

5. Follow this example, and make the necessary explanation as clear and as brief as possible. Unless the exhibit is for educational purposes in a professional group, do not use innumerable little cards of explanation attached to all the items of the display. A streamer across the back of a show window, at a single sentence or two of interpretation or the side of the exhibit ordinarily is sufficient.

And no matter what form you use to inform the public about nursing, remember always the two great commandments in public information:

1. Write for the possible patient. Talk for the public. Present all information so that it will interest the layman because it is related to his needs and, therefore, he understands and is interested.

2. Be accurate. Reduce your material to the few essential facts, then develop these as you think best.

EDITOR'S NOTE.—This is the fourth article to appear in the *Journal* in this publicity series and, like the others, is designed to reach particularly state and district officers, publicity chairmen, executive secretaries, registrars, hospital training school superintendents, and others upon whom rests the responsibility of public information in nursing.

The Public Health Nurse for April

Official Magazine of the National Organization for Public Health Nursing

(May be had in combination with the *Journal*)

Birth Palsy. By Philip Lewin, M.D.
Nursing and Insurance in Great Britain. By Irene H. Charley
Prenatal Program in Franklin County, Alabama. By Frances E. Page.
Cerebro Spinal Meningitis. By Rockwell M. Kempton, M.D.
Summer Schools and Institutes, Summer, 1930.
Rural Nursing in Hungary. By Alexandra M. Wacker.
When the Public Health Nurse Handles Her Own Publicity. By Alfred Powers.
Hourly Appointment Service Visiting Nurse Association, Detroit. (Of particular interest to private duty and other nurses who are studying Hourly Nursing.)
Planning a County Nursing Program. By Margaret Reid.
News from the State Division of Maternity, Infancy, and Child Hygiene, New Hampshire.
Foods of the Foreign-born. By Bertha M. Wood.
Nurses in Commerce and Industry (*continued*). By Louise M. Tattershall.
Organization Activities:
N. O. P. H. N. News.
Comments on Revision of the by-laws.
Additional Recommendations of Records Committee for P. H. N. Reports.
Board Members' Forum.
Biennial Program.
Industrial Nursing Questions—Problems and Policies Department.

ENTRANCE TO ST. ELIZABETH'S SCHOOL OF NURSING, YAKIMA, WASHINGTON

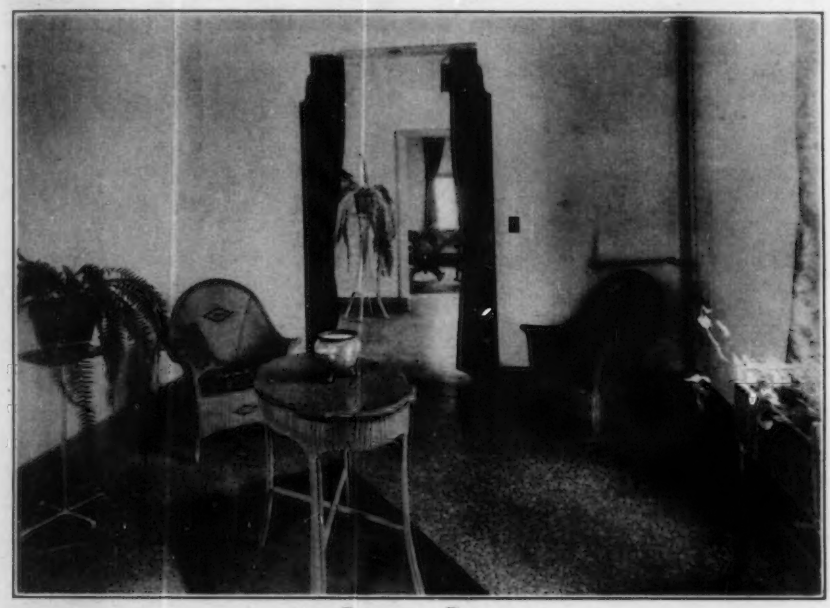
(It is understood that the capes are used only when necessary between hospital and home. Good practice condemns the use of uniforms with or without caps on public thoroughfares. Ed.)

St. Elizabeth's Hospital School of Nursing

SISTER JOHN GABRIEL, R.N.

ST. ELIZABETH'S HOSPITAL, of Yakima, Wash., operated by the Sisters of Charity of Providence, one of the pioneer orders of the Northwest, has recently completed a long-looked-for and much needed home for its student nurses.

To the casual observer or the ardent lay worker, it sometimes appears as what frequently resembles a venturesome undertaking; and so the dream of the St. Elizabeth's School of Nursing is at last realized and from all appearances it is "here to stay," as it is a three-story fireproof structure with a capacity for over one hundred nurses, fully equipped with every modern device, from the tiny red pilot



RECEPTION ROOMS

if the Sisters are the hardest people in the world to move, they do seem so conservative, but those who are more familiar with the ways of various religious orders know that when the Sisters do move, they take great strides and usually arrive in time to meet the requirements of the day. There is, too, a certain stability about what they do that makes for permanence and gives the "here-to-stay" feeling to

light on each floor indicating in one case that the automatic elevator is in use and in another that the process of general ventilation is taking place, up to the large auditorium, with its roomy stage, brilliant footlights, and seating capacity for approximately six or seven hundred people.

St. Elizabeth's Hospital has served the residents of the Yakima Valley and the surrounding districts since

A Classroom

1891. Its process of growth has been constant, from the mustard seed that was a little frame building to the rather imposing brick structure with beds for one hundred and twenty-five patients and, at that, every possible space is engaged long before it is available. So congested have been the conditions at St. Elizabeth's, that the nurses' apartments were retrenched and retrenched in favor of patients, until at last the nurses were crowded completely out of the hospital building into their new home adjoining the hospital, where they are surrounded with everything that makes for the best educational, cultural, and social environment.

Two of the three floors of this building are given over entirely to sleeping rooms, all of which are single with the exception of a few double rooms. Each room is furnished with window drapes, a bed, dresser, rocker, straight-back chair, table, a large spacious locker and a set basin with running hot and cold water. There are lavatories and utility rooms at either end of these floors, with basins, bathtubs, showers, a large mirror, and plugs for electric curlers. The utility rooms contain the incinerator, clothes chute, mop shaker, clothes drier, and cupboards for brooms, mops, etc. All the rooms are well lighted and ventilated by both natural and mechanical methods.

The main floor is taken up with a full teaching unit including a well lighted classroom, demonstration room, science room, and library, each one of which is provided with the

necessary equipment to carry on its work. The remainder of this floor has been thought out and planned to give the student a cultural and social environment that would go far toward establishing and retaining the proper kind of home ideals and standards of living. An attractive part of this floor is a large living room, with ample space for seventy-five or one hundred persons at one time. This room is appropriately and substantially furnished with modern and well selected furniture. It is colorful and artistic, with its harmonizing draperies,

LATE BREAKFAST IN THE KITCHENETTE

rugs, pictures, and walls, all of which radiate an atmosphere of home life and restfulness which is enhanced by the addition of a cheerful fireplace, radio and piano, and an adjoining kitchenette which makes it possible to enjoy a cup of tea or coffee, or to

ONE OF THE OFFICES

serve it to guests, with very little inconvenience.

The kitchenette is equipped with an electric range, frigidaire, cupboards for dishes, and a sink with hot and cold running water. It is an unusually large room for a kitchenette, so that it affords a corner for a cosy little breakfast room which is daintily furnished in green and cream with the color scheme carried out in table, chairs, draperies, dishes and linen. This is one of the most popular rooms in the house, catering not only to visitors in the living room but also to students who, on a free day, may enjoy a late breakfast at any hour they wish to rise.

Private parlors are also available on this floor, and these are attractively furnished with upholstered and wicker furniture, which makes them very inviting and much appreciated by the students who entertain men friends.

The Sister Directress' and the House Mother's offices are a part of the main floor and either one or the other is open to students at any time during the day or the night. The additional space is taken up with sewing room, linen room, utility room, lavatories, and auditorium. The basement is used for laundry and storage.

Ice water circulates throughout the entire building with fountains on each floor. A telephone booth on each floor is provided with a light and a shelf for the book. The walls are protected for about two feet above the shelf around the inner side of the booth by vitrolite, which prevents many a promising cartoonist from exercising her talent while waiting for an answer to a call.

The St. Elizabeth's School of Nursing admits only students who have completed a full high school education, who have a good moral character, and show an ability to carry the theoretical and practical work of the curriculum, as outlined by the Board of Examiners for an accredited school in the State of Washington. The school employs a full time instructor who is assisted in her teaching by the directress of the school, the supervisors on the floors, the dietitian and the medical staff.

May Day, 1930, and the Parents

THIS year May Day addresses itself to the fathers and mothers of the United States. Upon them depends the success of all efforts to ensure a sound mind in a sound body to every child. Therefore, the National Child Health Day Committee of the State and Provincial Health Authorities of North America chose as the special keynote of 1930, "Parent Coöperation in Community Child-Health and Protection." They know that the state's official health work will be effective for children in proportion to the intelligent coöperation of the parents of the little John's and Mary's and of their baby sisters or brothers.

The time has come when parents ask for something more than ever before. They ask to be drawn more actively into the program, to be better informed on the whole subject of child health, to know what each separate group, working in this field, is doing and how its work fits into the whole. They are ready for a new and clearer interpretation of the community's child health program and of their responsibility for it.

Magazines and newspapers can and do help by every line which they carry on the well-being of children. If a news item or an article rouses a mother's interest and makes her realize that to be a good mother requires knowledge as well as instinct, it has accomplished much. And if in addition, the other health forces provide her with the means of acquiring further knowledge, still greater progress is made to that most important of all goals—intelligent coöperation.

These are some of the things of which May Day—National Child Health Day, 1930—reminds us. May Day asks of us all—parents and health workers—intelligent coöperation in the nation's child health program. The President can call a White House Conference on Child Health and Protection; others can say "Let us consecrate May Day to the children of the United States"; but only parents by their coöperation can make the results of the Conference practical in the life of the child, and can translate the ideal of May Day into child health, child happiness, and child success.

Some Problems of Private Duty Nursing[1]

MARY F. WALLACE, R.N.

THERE is nothing original about what I shall say, but having been a private duty nurse twenty-six out of the thirty-three years that I have been in active nursing service gives me the only right I have to take your time. Many problems, national in scope, have been brought to our attention by the Grading Committee in their first report contained in *Nurses, Patients and Pocketbooks*, that wonderful "little red book" issued more than a year ago. The questions of supply and demand are definitely known, backed up by printed facts. We have facts as to the low preliminary educational background of many of our nurses of the past and the present, and this gives the key to the future.

It is quite frequently remarked by some of our private duty sisters: "What is the use of my joining any nursing organization or attending meetings? There is nothing in them for a private duty nurse." This attitude reminds me of a story I heard the other day of a hard-working preacher who was addressing a small congregation. The service proceeded until time to take up the offering, which was to go to the man occupying the pulpit that day. The good deacon passed the plate to the visiting parson as well as to the congregation and the faithful preacher dropped in fifty cents. At the close of the service the deacon apologetically returned the fifty cents to the preacher, whose small son remarked: "You didn't get much, did you, Daddy?" "No," replied Daddy very sadly. After a moment's thought the little boy said: "Maybe you would have got more out of it, Daddy, if you had put more in."

That is somewhat like the private duty nurses. Maybe we would find more information, more inspiration for our problems and work if we put a bit more into the solution of them ourselves; if we expressed ourselves to some purpose in a nurses' meeting, instead of in such fluent criticisms in hospital dining rooms, where the chatter only increases our discontent without offering the first constructive suggestion.

Along this same line, I was a bit amused at some remarks from a very pleasant nurse on board the boat to Montreal this summer. She was from a state a little south of the Mason and Dixon line and, after finding that we were both nurses bound for the I. C. N., she asked if I had ever attended an international meeting before. I told her no, this was my first thrill along that line. Then she asked me if I had attended many of our national meetings, and I had to tell her I had had the opportunity of attending only four and asked her if she was at our last Biennial in Louisville in 1928. "Yes," she said, she went, but she did not get much out of it. "They had so little for the private duty nurse." "Oh!" I said, "I thought our Private Duty Section meetings were fine. They discussed group nursing, hourly nursing and registries." "Well," she replied, "I guess I did not get into those meettings. You know it rained all the time, and anyway, there is always so much lost motion at these big conventions. It is so hard to pick out what one should hear." "Well," said I, "you got your program when you

[1] Read at the annual meeting of the Illinois State Nurses' Association, Moline, Ill., October 10, 1929.

registered did you not? I always look over my program and select the things I most want to hear. The general sessions are usually of interest to us all and the Private Duty Section program is of special interest to our group." "No," she said, she did not register and she never did get a program. She just "dropped in" to first one meeting and then another, but she did not find anything that interested her very much.

"Well," I said, "when you get to Montreal be sure you register the first thing and get your program and study it. You will not be able to take in nearly everything, but pick the papers that interest you most. If you take our *American Journal of Nursing*, you will find that it has given an outline of the program and you could get an idea of what was most interesting to you." "Yes," she said, she took the *Journal* and thought it a very fine magazine but she did not have much time to read.

"Nurses are pretty busy in your part of the country, are they?" I asked. No, there had not been a great deal of work. Some nurses were not busy much more than half the time.

"That agrees with the report of the Grading Committee in *Nurses, Patients and Pocketbooks*," I replied.

She thought she had heard something about the Grading Committee but she did not know just what they were doing and she did not know anything about *Nurses, Patients, and Pocketbooks*. I tried to explain that this important little "red book" was an outstanding feature of the 1928 Biennial, that it was $2 a copy and could be bought at the office of the Grading Committee, 370 Seventh Avenue, New York City, that every nurse should read it no matter what line of nursing she was in, but that it was a special study of private duty, all of which and much more she could find in the *Journal*.

This type of nurse is, to my notion, one of our most serious problems. She belonged to her District, she took the *Journal*, but she got nothing out of either because she put nothing in either, not even a few hours of reading. I have no doubt she was very pleasant in the sick room, probably gave very good bedside care, just as it had been taught her in her training school, but I doubt if she had taken the trouble to acquire any new technic or add much to either her professional or general knowledge in the ten or twelve years she had been out.

If private duty nurses are idle four months out of every twelve, even if the time does come in one day or two or three at a time, surely we could find some time to do a little reading and keep somewhat abreast of newer nursing ideas and the current topics of the day.

Some of us here had the very great pleasure of hearing Miss Geister and Miss Fox give their very splendid papers in Montreal. We can all read them in the *Journal* though we will miss the thrill of the big audience and the glowing personalities of these two fine women.[2] They will bear reading many times for they not only present problems but also some very possible solutions.

Our Grading Committee found no shortage of private duty nurses so far as numbers are concerned, but rather an over-supply with poor distribution. Miss Geister feels strongly that properly organized nurses' registries will help solve many of our problems, especially that of better distribution of nurses. Quoting from

[2] Miss Geister's paper was not published because her philosophy permeates all the A.N.A. news in the *Journal*.—EDITOR.

her paper "Private Duty Nursing in the United States" she says:

> The form of nurses' registry which has the approval of the profession is the nurse's official registry, organized and maintained by district branches of the state associations of graduate nurses. So important do we believe the registries to be, that a study of registries with a view to establishing minimum standards is the major field work project of the staff of the American Nurses' Association this year. Briefly, the development seems to be away from the function of a simple employment bureau toward the function of a community nursing bureau. We look to the registry to take leadership in developing nursing service proportionate in amount and kinds to the needs of the cases.

As I understand this paragraph, the registry of the future will not only have the placing of nurses on twelve and twenty-four hour private duty cases in homes or hospitals, but will also furnish a part-time service, as is expressed in hourly and group nursing, for home or hospital and, by some coöperative plan with visiting nurse and other public health organizations, will aid in a real community nursing service. As individuals we can do very little. In an organized coöperative group we can be of great assistance. Any plan for a real community nursing service must be worked out jointly by those prepared to give the service (the nurses) and those needing the service (the community, which includes patients, physicians, and hospitals).

I believe we private duty nurses are a bit afraid of some of these suggestions for part-time nursing service instead of the full-time type that has been ours for the past fifty years. We do not mean to be selfish but it just seems to some of us that the hourly nurse in the home and the group nurse in the hospital would rob us of work which we feel should be ours by right of both inheritance and training, and we do not welcome to membership on our registries the individual nurses who wish to try out these services. This is very shortsighted on our part, for boards of directors of registries are going to have to take on these part-time services if they fulfill their duty to the profession and the community, and we private duty nurses, by coöperating and becoming a part of these new services, will not only find wider employment for ourselves, but we can through our registries maintain better standards for these services to the "purchasing public" and some sort of regulation of the individual nurses rendering the service. Miss Nelson, in the July, 1928, *Journal*, closes her discussion of Distribution with these words:

> Together is one of the most inspiring words in the English language. Coming together is a beginning—keeping together is progress—working together is success.

Let us keep in mind the "human triangle" spoken of by Dr. VanEtten in his address in Louisville at our Biennial. This triangle is composed of the patient, the doctor, and the nurse.

If we private duty nurses of Illinois still wish to do bedside nursing because we like it and because we feel that is what we are best prepared to do, we must meet the new adjustments that are inevitable on account of changing social and economic conditions. We are a part of the communities in which we live and like all other individuals in these communities we have to meet the ordinary living expenses of shelter, food, clothing, educational things of one kind or another, our own illnesses, and sometimes the illness of those at least partly dependent upon us. So, like the rest of the community, our work must supply us with cash to meet these common necessities of the day and something for the days when we cannot

work, either because of illness, old age, or lack of opportunity. Our nursing is our business as well as our profession and the Chamber of Commerce of the United States has outlined a principle of business thus, "The reward of business for service rendered is a fair profit, plus a safe reserve, commensurate with risk involved and foresight exercised." This principle emphasizes four points, says Sister Irenaeus in her paper on "A Fair Reward" in our *Journal* of August, 1928, fair profit, reserve, risk, and foresight.

The nurse exercises foresight in her training for her work and in her care of her patient to prevent further illness. She certainly runs a considerable risk to health in caring for many communicable diseases. With irregular work and the usual expenses of living does she have an assured profit or reserve? Facts say not.

Miss Fox in her paper, "The Financial Aspects of Medical and Nursing Service," given before the Private Duty Section of the International Congress of Nurses, gave us three factors that have to be considered in studying the economics of any business or profession:

1. The cost of production
2. The purchasing power of the people
3. The need of the product (care, prevention)

A study of these three factors will tell us why private duty nurses must readjust their service to the community and give this service in part-time as well as full-time quantity. If, by reorganizing our present registry plans and coöperating with some already existing agencies, we can put our "product" within the purchasing power of the people and give private duty service "in accordance with the patient's need rather than his income" we shall have benefited ourselves as well as our community.

In the "Story of the Automobile" by H. L. Barber, there were a few pertinent paragraphs that might apply to private duty nursing business. The chapters devoted to the commercialization of the automobile make clear that

> Its greatest success has been due to the production of automobiles at a price within the reach of people of ordinary means. For this the one man most responsible is Henry Ford. He demonstrated that the most money is to be made out of things used by the greatest number of people—the things that are common needs.

When you are sick you need care whether you can afford it or not. The presence or absence of your bank account has nothing whatever to do with your need. Now, if a plan can be evolved where skilled nursing service can be brought within the purchasing power of 75 per cent of our communities instead of 10 per cent, or 15 per cent as Miss Fox gives our present estimate of those who can afford private duty nursing, under the heading "The Purchasing Power of the People," will we not have done ourselves quite as great an economic favor as we will have accorded our patients? This all sounds coldly commercial, but remember it is economics we are talking about.

Hospitals offer various accommodations that more or less meet the economic conditions of their patients. They have made many adjustments and have gone forward wonderfully in the past fifty years. Many things have contributed to a revolutionized medical practice in that time. Private duty nursing is just about where it was fifty years ago so far as its distribution is concerned.

Private duty nursing always has been an important part of the whole, since nurses were regularly trained and I believe it always will be. That 86 per cent of the large body of nurses

were satisfactory to their patients, and that these same patients said they would be glad to have the same ones again, is not so bad. That as a group we do fall behind the institutional and public health nurses educationally is indisputable and the reasons are not hard to find.

The splendid spirit of nursing, handed down to us by our pioneers is not dead. No matter in what units of time the bedside care of the immediate future may be given or in what manner it is paid for, it is still ours to live up to our International watchword of "service." That some of us are not all that our profession and their employers could wish and have a right to expect is undeniable. These tremendous problems of overproduction, poor distribution, and unemployment will be solved.

Nurses have a social conscience and they will find a fair way of evening up the less desirable things incident to our private duty work—such as taking country cases, communicable work, dividing up holidays and week-ends so that registrars, doctors, and patients will not have so many of these preventable offenses to lay at our door.

Whatever adjustments may come in the future, so that all who need care may have it; however much our hours of service may be shortened, and they certainly do need shortening (No one but a mother puts in the long hours that nurses often do), we older nurses who have weathered these undesirable conditions can sit back in our chairs in the old ladies' homes and can enjoy in retrospect the many fine characters it has been our privilege to care for and the rich friendships that service has brought us. These compensations don't pay rent, but they are very sweet.

We cannot afford to be indifferent or uninformed about our nursing world and other things about us. If we do not want to improve ourselves we must not block the traffic for others. We must inform ourselves of social and economic changes and be ready to make readjustment—not wait until they are thrust upon us whether we will or no.

From the trend of things, it would seem that reorganizing our present registries and organizing new ones, with the community nursing plan in mind rather than just a nurses' employment agency, is one of our first steps. For this reason, I move that the Private Duty Section of the Illinois State Association of Graduate Nurses send a request to our National Headquarters to have the subject of Registries made a special feature of the Private Duty Section program at our 1930 Biennial, with special reference to the organization and minimum standards for official District Registries.

[The discussion of registries and the formulation of minimum standards for official registries will constitute a very important part of the program at Milwaukee.—EDITOR.]

Evolution

Now the times change, the ancient lore gives way,
Or meets the keen, relentless test of science.
As blacksmith grew to engineer, and barber became surgeon,
The kindly neighbor now is nurse; and studied skill
Adds to the art of friendly ministration.

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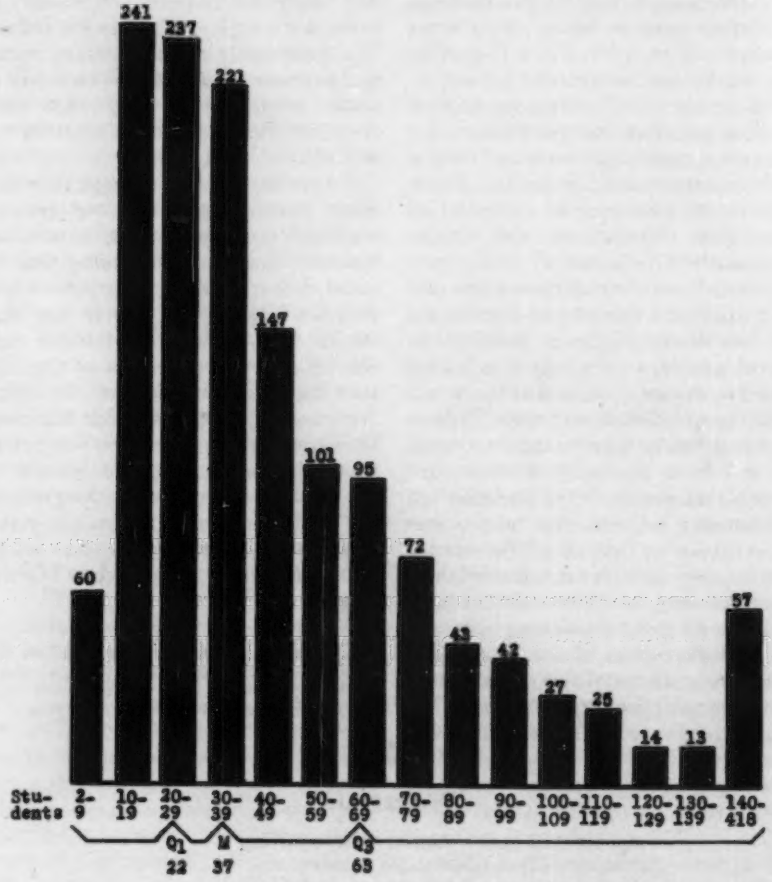
How Many Students Have They?

TO educators familiar with other professions perhaps the most incredible thing about schools of nursing is how very small they are. Half the nursing schools in the United States, if the grading figures run true to form, have a total student body of 47 or less, which means a senior class of about 10. And one-fourth of all the schools in the country have 22 students or less in the entire school. To educators who are accustomed to thinking of a college senior class of 50 as small, these figures are difficult to grasp; yet they are accepted generally by the nursing profession as representing a normal condition.

The diagram which accompanies this article is based on reports from 1395 accredited schools taking part in



Schools having each size of student body. Heights of columns represent numbers of schools of each size. Affiliating students from other schools not included. Diagram based on reports from 1,395 regular accredited schools which have joined in grading study

the grading study; and is so devised that the height of each column indicates the number of schools which belong to each group, when the schools are arranged in order according to their numbers of students. The notations M, Q_1 and Q_3 show in what columns the middle and the first and third quarters fall.

There are exceptions, but in general it is true that the figures in this diagram closely follow the figures presented last month for the daily average patients in the hospitals to which these schools belong. In general the small student body is attached to the small hospital, and the larger the hospital grows, the more its school is expanded. These statements are matters of everyday knowledge in the nursing profession, and they are also substantiated by previous studies made by the Grading Committee.

There are 60 schools which have a student body of 9 students or less. One of them has only 2 students in the school. There are 241 others which have from 10 through 19 students. At the other extreme of the distribution is a column of 57 schools in which the numbers of students range from 140 through 418. These are the very large schools. Most of them are steadily expanding, so that in many cases this year's entrance group is larger than in any previous year in their history.

What do nurses think about this question of size of school? If the experience of the Grading Committee is a safe guide, we can say that, in general, superintendents of nurses who are connected with the large schools feel strongly that because it usually has so little to offer in clinical material the small school is a handicap to the profession and should be eliminated; while principals of the smaller schools believe that the large school loses something when it herds its students together in such great numbers. They hold that nursing can best be taught by individual contact with the head of the school, and that in such large places this kind of detailed supervision becomes impossible.

This latter argument is convincing when presented to those who are closely connected with schools of nursing and almost equally unconvincing when presented to educators on the outside. In very few of the other professions are schools regularly conducted on a one-man or one-woman basis. In most professions it is assumed that the head of every school will have a staff of carefully selected faculty members who, among them, will share responsibility for giving each student the broad professional experience and the individual guidance he needs as a preparation for true professional service wherever placed. Often the great schools are singularly successful in their watchful care for the individual student, but they do not achieve this success by expecting the president of the university or the principal of the school to be familiar with every detail of the student's daily life and every phase of his emotional and mental growth. They delegate parts of this responsibility to other members of the staff.

In nursing, however, in perhaps a majority of the schools, the superintendent of nurses still feels personally responsible for the instruction and development of all her students. Where this is so, it may be inevitable that schools which have rapidly expanded, but have made no essential change in organization, should feel the danger of losing touch with the student body. The argument, "Large schools produce good machines, but don't produce good nurses," probably finds its source in cases where schools

have grown but there has been no corresponding development in the organization of the teaching staff, and no carefully worked-out shift of responsibility from the shoulders of the superintendent of nurses to the shoulders of carefully chosen educational assistants.

That large nursing schools can exist and can at the same time give more than surface attention to every student in the school is fortunately being demonstrated in a number of well known institutions. There are still, however, many superintendents of nurses who hold positions as directors of the small schools and who would earnestly defend their doing so, first, on the ground that after graduation their students will serve only their own community, and so will have little need for broader preparation; and, second, because they believe that individual personal contact with the principal offsets whatever deficiency there may be in clinical material or formal classroom instruction.

Here is another question where standards are surely needed. The superintendent of nurses who accepts the position as head of a very small school in a small hospital needs guidance from other nurse educators. She would probably hesitate to accept such a position if she had reason to believe that she would be frowned upon by the women she respects in her profession; yet unless some definite suggestions are given as to a minimum below which schools of nursing will not meet with the approval of nurse educators, she is at a loss to know where to draw the line.

More than rulings from state boards are needed. Every school represented in this study is practising with permission from its state board. If the more thoughtful leaders in nursing education, after carefully weighing the many elements in the educational problem, could agree upon a minimum number of students below which no superintendent of nurses should feel justified in conducting a school, might they not make it easier for nurse superintendents in the field to define their own responsibilities?

This article and the article "How Many Patients" on page 290 of the March *Journal of Nursing* consider the minimum essentials which justify a superintendent of nurses in assuming the responsibility for conducting a school. How many patients must the hospital have as an absolute minimum? What sorts and varieties of clinical experience must those patients offer? How many students form the smallest student body which can be handled effectively? Can the hospital with the very low patient average or the very small student body ordinarily hope to provide an adequate teaching staff including instructors, supervisors, and head nurses especially prepared not only for nursing but for teaching? Can such a hospital usually see its way clear to provide ample laboratory facilities, classrooms, textbooks, and teaching equipment? These and similar questions are comprised under the general inquiry "What are the absolute minimum essentials which justify a superintendent of nurses in assuming the educational direction of a school of nursing?"

THE Nurses' Association of China writes that there is a doctor in China with British degrees (assumedly Chinese) who is just restarting the railway hospital in Shanghai. He asks every nurse who applies for a position the number of her N. A. C. diploma (corresponding to state registration certificate in this country). He assumes that anyone who does not know her number is not active enough in the profession to make a good nurse for his hospital.

Sodium Amytal

An Intravenous Anesthetic

MAE L. WHITFORD, R.N.

THERE has been considerable discussion in the medical profession as to the propriety of nurses administering anesthetics. However, a number of prominent surgeons in this country prefer registered nurses as anesthetists, because they are not watching the surgical procedures but devote their entire time and attention to the condition of the patient. For this reason my experience with a new anesthetic might be of interest.

Last spring while spending a week at the Mayo Clinic it was my great privilege to observe the administration of sodium amytal anesthetic by Dr. Lundy. The rapidity and ease with which the patient became drowsy and quietly entered into a seemingly natural sleep were so extraordinary that its value was particularly striking. When I returned and explained the anesthetic properties of sodium amytal its splendid advantages appealed to Dr. Collins so forcibly that he concluded to use it if possible. As it is not yet commercially obtainable, we were most fortunate, indeed, in securing the salt through the courtesy of Eli Lilly and Company.

Sodium amytal is a powdered salt (sodium iso-amyl-ethyl barbiturate). The solution is prepared with two ampules. In one ampule is 1.0 gram of the sterile powdered salt, the other contains 10 cc. of triple distilled water. As the estimated amount to be used is sometimes more than 1.0 gram it may be necessary to prepare 2 ampules of the solution. By means of a sterile syringe the distilled water is slowly added to the sodium salt and gently agitated until the salt is entirely dissolved, the air bubbles have disappeared, and the solution is crystal clear. If the solution shows any cloudiness, or opalescence, it *must not* be used. It has been necessary several times to prepare another solution.

A 10 per cent solution is used. The dosage is 15.0 to 25.0 milligrams per kilogram of body weight. We have discovered that the same dosage, according to body weight, differs greatly in effect with the age and vigor of the individual. We employ our usual preliminary medication as with other anesthetics; that is, ⅙ grain of morphin with 1/100 grain of scopolamin given hypodermically half an hour before the operation.

The patient's arm is prepared with the usual aseptic technic; we then carefully inject into the cephalic vein, very slowly, 1 cc. of the 10 per cent solution, per minute. From the beginning of the injection the patient is very comfortable; within two or three minutes he gradually becomes drowsy, is unable to answer questions coherently, and in another minute or two is profoundly asleep. It is a marvelous sight to observe the patient pass from consciousness to unconsciousness so serenely.

Shortly after the injection has begun, there is a decidedly sharp decrease in blood pressure. We therefore take blood pressure readings every two minutes during the injection and every five to ten minutes during the operation. We do this at the request of Eli Lilly and Company because the anesthetic is still in the experimental stage. While there is a marked fall in the blood pressure during the injection, it quickly regains its previous

level during the operation. In all our patients we have had drops in blood pressure, notwithstanding that we have used the strictest precaution in injecting the solution very slowly at the rate of 1 cc. per minute.

The most alarming drop in blood pressure that we have experienced was 74 points, systolic. This was in a female patient aged sixty-two. It has been the only case where a patient has had Cheyne-Stokes respirations. We were to inject 14 cc. of the solution, and after having injected very slowly about 5 cc., there was a sudden sharp drop in blood pressure with Cheyne-Stokes respirations, cyanosis and a pulse of 52. At one time the interval between the respirations was 20 seconds. The needle was immediately withdrawn. After giving 0.05 grams of ephedrin sulphate, followed by 0.5 grams of caffeine sodium benzoate intramuscularly, the blood pressure began to rise, the respirations gradually became normal, and the cyanosis disappeared. This operation was completed under sodium amytal without the addition of any other anesthetic. It is only fair to state that this patient was in a state hospital for a mental disease and there was no opportunity for examining her in our clinic. There may have been another cause for the symptoms besides the sodium amytal.

Ordinarily, the respirations are very quiet and regular during the injection but become more pronounced and deeper as the operation progresses. The color does not often change but there is, occasionally, slight cyanosis which is of brief duration. To prevent respiratory obstruction, such as the tongue falling back in the pharynx, it is wise to make use of the airway at times. There is no postoperative nausea or vomiting. This is very desirable for the comfort of the patient. Our patients usually sleep about nine hours and then waken for a brief period of a few minutes and answer questions intelligently. They again go to sleep and sleep practically the entire night. If the patient shows any restlessness, a small dose of morphin is administered hypodermically.

Some of our patients have been operated on with sodium amytal alone; but, with a few exceptions, the patients have become restless during the ether preparation of the skin, and also when the incision was being made. Therefore, we commenced to supplement sodium amytal with nitrous oxid and oxygen when the incision was to be made, thereby obtaining a smooth anesthesia. The amount of nitrous oxid required was considerably less when used in conjunction with sodium amytal. Sometimes it was necessary to introduce a small amount of ether. Frequently the inhalation anesthetic can be discontinued as soon as the skin incision is made. We do not use ethylene because of its explosive properties.

Thus far we have met with but two patients in whom we were unable to find a cephalic vein of sufficient size. However, we were successful by injecting the solution into the left external jugular vein in the first patient, and into a large vein on the wrist in the second patient. The results were very satisfactory in both patients.

Sodium amytal has a wonderful advantage in cases of extremely nervous and apprehensive patients who have a dreadful fear of the operation. The solution can be easily injected while the patient is in his room and after he is asleep he can be removed to the operating room. Consequently, he will not have any knowledge of the operation till it is over. To us sodium amytal seems

ideal for this type of patient. Some patients who have had an experience with an ether anesthesia fearfully dread another and sodium amytal may be advantageously administered for the second operation instead of ether.

Our patients to whom sodium iso-amyl-ethyl barbiturate has been administered have been very generous in its praise, appreciating the delightfully pleasant way in which they "went to sleep." As the salt is a new anesthetic, we are obliged to select our cases with extreme caution. So far every patient has been grateful for this intravenous injection and has made a most satisfactory recovery. We have learned that anemia is not a contraindication. The hemoglobin estimation on one of our patients was 65 per cent and on another 58 per cent. The effect of sodium amytal seemed to be a little deeper in the anemic patients.

The following is a partial list of operations which have been performed here under sodium amytal anesthesia: appendectomy, hysterectomy, salpingo-oöphorectomy, cholecystectomy, repair of cystocele, repair of rectocele, herniotomy, radical amputation of the breast, trachelorrhaphy, cauterization of the cervix, perineorrhaphy, and amputation of the leg.

A Retirement Income for Nurses[1]

MATILDA L. JOHNSON, R.N.

I HAVE been asked to come here and talk to you about insurance. I am not going to do it. At one time or another all of you have looked into the matter of life insurance protection, and it is not necessary to tell you about the different policies you can buy. You know that during your younger years, provided you are in satisfactory health, you can buy policies at roughly $20 to $30 a year for each $1,000 insurance. You pay these premiums and when you die the beneficiary you have appointed receives the amount of the policy from the insurance company. If you wait until you are older to take your policy your premium rate will be higher.

Any life insurance policy with a reputable company is good. The state fully protects you in your purchase. The insurance company is obliged to live up to the terms of the contract. Occasionally you make a mistake in making other purchases. You may pay your money for something that is worthless. You may be cheated by the tricks of sharp merchandising. This cannot happen to you in the purchase of life insurance. You always get what you pay for. The laws see to it that you do. In reality these life insurance policies with which you are familiar provide you with death insurance and not life insurance, and their purpose is to protect dependents who survive you.

I am going to tell you something about a form of insurance that is really life insurance in that it is designed to pay you an income beginning at some appropriate age and continues to pay it as long as you live. I know that from time to time all of you wonder what you are going to do when you are

[1] Read at the twenty-fifth anniversary of the founding of the Ohio State Nurses' Association, April, 1929, and published in the *Quarterly Bulletin* of the Association, October, 1929.

no longer able to earn your living as nurses. I am sure that most of you make some effort to put money away as savings to anticipate the time when you can no longer carry on your professional duties.

Nearly all of us have dependents to whom we are bound by the ties of love and moral obligation. In some cases the degree of dependency is considerable, and in others not so great. You all willingly acknowledge these obligations to dependents and provide for them to the best of your ability through the life insurance policies you carry. But it is not fair for any dependents to expect you to totally ignore the problem of provision for your own future years when you may not be as fortunate as they are in having some one take care of them. It is about this provision for your own future that I am going to talk to you.

During the last few years the problem of provision for old age security that confronts self-supporting women has received a constantly increasing amount of attention. Already much has been done to assist the women engaged in the teaching profession in this respect. There is, of course, no reason why members of the nursing profession cannot provide for their futures in very much the same way as a great many teachers are providing for their futures. Up to a short time ago we were handicapped in this connection because no one had done anything to establish an organization through which we could act.

Fortunately, Mr. William E. Harmon, who has for many years been well known for his splendid philanthropies, became sufficiently interested in the plight of the members of our profession actually to set in motion investigations to see what might be done to help you. Mr. Harmon was unfortunate enough to be ill a large part of the time during the last years of his life, and the attention he received from the nurses in the hospitals where he was forced to seek treatment was largely instrumental in bringing him to his decision to do what he could.

The nursing profession has a very large membership. If Mr. Harmon had bequeathed two, or three, or five dollars to each nurse at his death, none of you would have derived any great benefit from his philanthropy. A million or more dollars might easily have been consumed in this way to accomplish substantially nothing. It does not take much reflection to realize that neither Mr. Harmon nor any other individual could really help the nurses of this country toward old age comfort and security by providing them with money on which to live after they have ceased nursing.

Under the circumstances Mr. Harmon did a much sounder thing than he would have done had he left each of you some trifling sum. Since he could not possibly help you directly, he devoted the sum of $50,000 for the organization of the Harmon Association for the Advancement of Nursing. He did this because by doing it he could help you to help yourselves, and in this way achieved a great deal more than he could have achieved by dividing his estate among the numbers of the nursing profession.

When the Harmon Association was organized, various people, including leaders of our own national nursing organizations, were invited to sit as a committee to discuss this problem of old age dependency which all of you must face, for the purpose of determining how you could best help yourselves to attain the old age security we all desire. Associated with the leaders of our profession were specialists in insurance, investment, and finance.

We are especially fortunate. In the past, efforts have been made to help the members of other professions toward old age security. Most of you are more or less familiar with the work of the Carnegie Foundation for the Advancement of Teaching. Through this organization teachers in the schools and colleges are able to provide old age incomes for themselves. When the Harmon Association was formed it was possible to have the advice of officials of the Carnegie Foundation and other experts who were familiar with various plans for providing incomes after retirement has become necessary. When the Carnegie Foundation was organized, there was virtually no such organization. The people who assembled it were forced to experiment more or less. When the Harmon Association undertook its studies, the committee carrying on this work was able to deal with experts here and abroad who had had years of experience with retirement plans. It was not necessary to step out blindly hoping that the conclusions the committee members reached would be satisfactory.

We are fortunate because in the Harmon Association there is created an agency able to distribute, for the benefit of the members of the nursing profession, gifts and legacies that public-spirited citizens may wish to leave. Heretofore it has been impossible for people so inclined to do anything in this direction simply because there was no organization through which it could be done.

Out of the deliberations of the committee assembled by the Harmon Association has come the Harmon Plan of old age annuities for nurses. The leaders of our national nursing organizations, working in collaboration with the various experts who were persuaded to assist them, early reached the decision that we could best provide ourselves with old age incomes by systematically putting aside small monthly deposits throughout our active working lives and applying these deposits for the purchase of old age annuities. The duration of life is uncertain. Some of us will live to very advanced ages and others will die much sooner. No one can tell how long life will last after retirement. Consequently none of you can tell at what rate to spend the estate you are able to accumulate. In most cases we are unable to build up estates large enough to pay a living income out of the interest they earn. It is necessary to use up the estate itself, and that is where the trouble comes, because we cannot tell how long we are going to live and therefore cannot tell how rapidly to spend the estate. Managing our own money, many of us will spend it all before death. Others, fearing that it will be completely used before they die, will live very meagerly when it is not necessary.

There is one ideal device for completely utilizing the estate of any individual and at the same time guaranteeing that it will last throughout life. This is the old age annuity. The annuity is a form of insurance which guarantees the payment of a stipulated income as long as life lasts, and so the committee of the Harmon Association assembled to study your problems concluded that the most advantageous investment for your savings is the annuity which will pay you a monthly income as long as you live. When the committee had reached this decision it remained for it to decide just what sort of an annuity plan would be the best suited to the needs of the nurses.

In the first place, annuities deal with mortality and investment. The management of annuity plans is con-

sequently the business of an insurance company. Years ago when the Carnegie Foundation was investigating prior to the construction of its old age annuity plan, the people who were making the investigation finally concluded that teachers could best provide themselves with old age incomes through an annuity plan. An effort was made to interest the executives of insurance companies in the underwriting of the Carnegie Plan of annuities for teachers. Even as short a time ago as the days when the Carnegie Foundation was being organized, it was obliged to go ahead alone. It was not possible to secure insurance company coöperation. Since that time there has been a change. The Harmon Association has been able to effect contracts with the Metropolitan Life Insurance Company, the largest financial institution in the world.

The Metropolitan has agreed to act virtually as a trustee for the plan. All the deposits that you as members make in the Harmon Association will be held by the Metropolitan to ensure full safety. This insurance company is a mutual organization operated without profit to anyone except its policyholders. It guarantees you complete protection against the loss of a single penny.

When the committee carrying on the negotiations and investigations had concluded that the most satisfactory solution of the problem we face lies in the accumulation of old age annuities and it had made arrangements with an insurance company whereby these annuities could be underwritten and guaranteed, the final step remained. It was then necessary to actually determine what the details of the plan would be.

At this point, even more than theretofore, the members of the committee who were themselves nurses were especially helpful. No one could know better what you and I need than the leaders of our national nursing organizations. They themselves are nurses with years of experience behind them. They have encountered and are encountering problems that we too are familiar with. These experienced nurses virtually dictated the provisions of the plan. Therefore the provisions are the provisions that you and I need. They are the provisions we would have recommended had we been sitting with the committee.

I am now going to outline briefly the provisions of the Harmon Plan of old age annuities for nurses.

Each registered nurse is eligible to join the Harmon Association. The dues for membership are $1 annually. Membership in the Association is membership in the plan. Under the terms of the plan you can make monthly deposits of $5 or any multiple of $5 to the Harmon Association. These deposits are placed with the trustee of your funds—the Metropolitan Life Insurance Company. The deposit can be continued regularly up to the time you are ready to retire. The amount of the income is, of course, governed by the amount of the monthly deposit and the number of years it is continued. Your old age income will begin at any time from age 50 to age 65. The choice of the age at which the income begins rests with each nurse herself.

Some of you may have already passed many years in the profession. Perhaps there are only a few years left for you to accumulate old age incomes. Those of us who are in this position can augment the old age income secured by the monthly deposits we make, by placing all or part of our savings in the Harmon Plan immediately and further adding to

our old age income by depositing other considerable sums that may come to us in future years.

All money that you put in the plan will be paid to your estate if you die before you retire or, if death occurs after retirement but before you have received as large an income as the sum of your deposit in the plan, the difference between the total sum of your deposits and the income you have received will be paid to your estate.

If it becomes necessary for you to suspend payments at any time and take out the money you have put in the plan, you can always get back at least as much as you have deposited. If you choose, you may signify your wish when you subscribe, to receive a cash surrender value equal to your deposits plus compound interest, but if this option is chosen you will draw a substantially smaller income at retirement than you would have, had you paid the same amount of money and not taken the option.

Your income is guaranteed to you by the Metropolitan Life Insurance Company. Starting at the maturity date you choose, you will receive a check every month from the Metropolitan Life Insurance Company as long as you live.

As soon as you join the plan you will receive a certificate book issued by the Insurance Company. This certificate book gives the terms of the contract and the guarantees that protect you.

Participation gives you a monthly income for your own use. When this income has once begun, it continues for the rest of your life no matter how long you live. Your payments will always be made to one central office and you will receive your monthly income check promptly wherever you live.

There is no surrender charge, if circumstances force you to give up and take your deposits out of the plan.

Your investment is absolutely safe.

In the case of an emergency you can borrow against your equity in the plan.

The Harmon Association provides a central organization through which funds from legacies, endowments, gifts, interest earnings, or other sources may be administered for your benefit. This is particularly worth noting. No one can tell how much may ultimately be realized for members in this way.

Finally, membership in the Harmon Association gives you membership in an organization established and operated to assist all registered nurses. It is guided by your own trustees and officers who are chosen by you yourselves.

This problem of making provision for ourselves in old age is very important. In many cases we are completely ignoring it and very few are giving it the attention that we should. We cannot be expected to know as much about ways to reach old age security as others whose business it is to know about these things. I am sure that each of us will find in the Harmon Association an institution anxious to give us help and recommend it as a source of information for any one wishing unbiased advice.

A Hospital Fire

WINIFRED FITZPATRICK, R.N.

"With loyalty . . . to the welfare of those committed to my care."—NIGHTINGALE PLEDGE.

ON Sunday morning, February 23, a fire broke out in St. Joseph's Hospital, Providence, R. I., causing a large property damage, but the 162 patients in the hospital at the time were promptly rescued and carried to safety in the Nurses' Home, across the street, and within four hours all were comfortably housed in other hospitals in the city, all of which opened their doors, as did many other institutions and homes, demonstrating the wonderful spirit of coöperation and helpfulness that exists in Providence. The maternity cases, new babies, and children were removed first, one of the babies having been born just thirty minutes before the fire was discovered.

The rescue work was carried on under the direction of the Superintendent of the Hospital, Sister M. Plautilla, of the order of St. Francis, the Directress of Nurses, Evelyn C. Mulrennan, and Margaret Murphy, Supervisor of the Maternity Ward, and they were ably assisted by the entire corps of Sisters, graduate and student nurses. A large number of citizens, attracted to the scene of the fire by the sounding of the fourth alarm, the police department and firemen, all rendered invaluable assistance in carrying the patients to safety. Many of the medical staff arrived early, and their assistance was also invaluable.

The fire was discovered about 6 a.m. The day force of Sisters and nurses were attending Mass in the hospital chapel. On the discovery of the fire a nurse entered the chapel and whispered to Miss Murphy that there was a fire. So quickly were the nurses mobilized and marched from the chapel, that the chaplain, while conscious of a commotion, did not know that the hospital was on fire until after he had finished the Mass.

Many witnesses of the rescue work paid high tribute to the efficient work of the nuns and the nurses, several of whom worked for hours in water above their ankles. Immediately on learning of the fire some of the nuns and nurses saw to it that the ether, oxygen, and x-ray films in their metal cases were removed from the building.

The entire work of succor and rescue was conducted with remarkable orderliness and composure on the part of the rescuer and the patients alike. There was no panic, and some of the patients did not know why they were being moved. One woman, on arriving at another hospital, remarked: "We were moved very quickly. Anyone would think the place was afire," and a child, awaking in another hospital, looked about him and asked: "Have we moved?"

Quick Thinking

BARBARA EDWARDS' final day in training in the School of the Emergency Hospital, Washington, D. C., was vividly unforgettable, for she received from the President of the Woman's Board, Mrs. Herbert Slocum, a gold medal "for exceptional heroism." Miss Edwards was on duty in the colored women's ward on the morning of January 25, when the screams of several patients attracted her attention to a patient who was dashing for the window. She ran in pursuit and overtook her as she paused to wrench open a window. A struggle followed, during which Miss Edwards and the patient came perilously near plunging to the areaway. The patient in question was thought to have been securely restrained by a special arrangement of the sheets.

Joyful News from Florence

ALICE FITZGERALD, R.N.

PERHAPS half a century late, but none the less welcome, will be the news that Florence, Italy, is to have a school of nursing, and to American followers in Florence Nightingale's footsteps the news will be most particularly gratifying, as it is the crowning achievement of a small but active group of our own countrywomen who have long been residents of that city.

During the war, in all Italian cities where they were to be found, and Florence was no exception to this rule, the foreign women volunteered for service with the Italian Red Cross. Those who had taken the local course of training for volunteer nurses were assigned to the numerous hospitals established in all centers of the country. A particularly fine group of American and British women labored long hours and contributed intelligently and efficiently to the care of the sick and wounded in Florence.

When the war ended, a number of these workers, who had "found themselves" in the world of toil and satisfaction previously unknown to them, decided that they would not hang up their caps and aprons just because the war was ended, and they conceived a plan which soon materialized and became the now well-known "Free Dispensary of San Domenico" near Fiesole.

A suitable building, standing in a lovely garden looking out on the Fiesole hills, was secured, and here for many years the Italians of the neighborhood have been receiving care from a volunteer force which includes well-known doctors and specialists, dentists, and also professional and volunteer nurses, foreign and Italian.

Success makes for success, and this enterprising group of foreign women soon cast longing eyes on vacant property next door. This was added to the original plant, but with this added space came new ideas and aspirations! "Why should we not build a hospital?" Then, as the final stroke of genius, "Why should we not start a training school for nurses?" No sooner said than done; and now news reaches us that the cornerstone of the hospital has been laid, that additional ground has been bought, and that Miss Baxter, as the non-resident director, and Miss Damele (an Italian nurse who graduated in New York), as the resident director, are laying their plans for the opening of the school with possible candidates already looming up on the horizon.

Under the sponsorship of able organizers, with the help of interested and competent medical men, and under the guidance of Miss Baxter, one feels indeed that this school has been born with a silver spoon in its mouth and that its path must lead to the success which it deserves.

The Cost of Medical Care

THERE is no doubt but that a change of some kind in our method of obtaining competent medical care for middle-class families will be necessary before we can go much farther with our public health program. —"Trends in the Field of Public Health," by Dr. W. P. Shepard, Metropolitan Life Insurance Company, in the *Red Cross Courier*.

Four Milestones

NORMS OF CHILD DEVELOPMENT

I. By his *first birthday* the child may be expected to:
   1. Drink from a cup and eat from a spoon (bottle discarded).
   2. Sleep alone, without artificial soothing such as rocking, pacifier or bottle.
   3. Have control of his bowels (when put on the nursery chair regularly, adult still taking the responsibility).
   4. Be content with little attention.

II. By his *second birthday* he may be expected to:
   1. Feed himself with cup and spoon.
   2. Sleep in a room alone—night and nap.
   3. Have control of both bowels and bladder.
   4. Have a dry bed at night.
   5. Pull off his own shoes and stockings, hat and coat, or any article which does not require too much undoing.
   6. Amuse himself alone with toys.

III. By his *third birthday* he may be expected to:
   1. Eat his entire meal without help.
   2. Undress himself.
   3. Wash himself and brush his teeth.
   4. Ask for the toilet.
   5. Play well with other children.

IV. By his *fourth birthday* he may be expected to:
   1. Serve himself at table.
   2. Dress himself and lace his shoes.
   3. Comb his hair.
   4. Wait on himself at toilet.
   5. Put away his toys without being reminded.

—Dorothy E. Hall (*Illinois*), *Mental Health Bulletin*. Quoted by *Mental Hygiene Bulletin*, November–December, 1929.

THE thing which is most fundamental for any permanent and substantial growth of rural social and health work is to arouse a sense of need for it on the part of the rural people, to make them aware of the amount of poverty and sickness in their own communities, and that for their own interest as well as to assuage human suffering, there should be an intelligent plan for its treatment and prevention.—"Trends and Problems in Rural Social and Health Work," by Professor Sanderson, Cornell University.

Schools for Segregation of Crippled Children

A May Day Celebration

ETHEL C. SCOFIELD

THE idea of the segregation of physically handicapped children has been meeting with much discussion. Arguments against it are always brought forward and many are of the opinion that it is better to have these children take their places in the regular public schools with the idea that they should be taught with the normal inasmuch as their lives will be spent in a world of normal, unhandicapped adults. Some also have advanced the idea that a group of crippled children has a depressing effect on the individuals of the group and that sensitive and sympathetic natures are affected in this way.

Let us take the case of a crippled child in a regular public school and see whether the advantages of being with normal children outweigh the advantages of segregation. In the first place the child is physically handicapped. That sets him aside as different. Usually his vitality is not as strong as that of the others and his inactivity necessitates greater care to prevent danger of exposure to heat, cold, dampness, and any extremes of excitement.

Children grow physically and mentally through active motions. To the handicapped child in the regular school these are prohibited because he cannot move quickly or readily; he cannot perform regular movements; the group is large and the teacher, fearful of danger, cannot do otherwise than have the handicapped child remain out of all activities involving moving about. He cannot take part in any public demonstration, as this would make his deformity conspicuous. The handicapped child is taking issue with a group that grows through activity, but he, who needs growth, is shut out from the activities and a sense of fear and inferiority is bound to result. Particularly is this true of the nerve-injury type where cerebral education is dependent upon activity. Fortunate is the handicapped child in the regular school who is not ridiculed or pitied and made more conscious of physical deformity. Nicknames—Peg Leg, Limpy Jim, Humpy Joe—keep the memory of a physical difference constantly before him. It is true that later in his life his place is taken among normal people. But is it not reasonable to suppose that segregated in a group, better preparation is made? Here the child is associated and competing with children who, like himself, have a physical handicap; he is on the *qui vive* to do his best; the element of fear is removed; he is not conscious of protection. There is no tendency to ridicule, for the consciousness of each individual's deformity creates a respect for the deformities in others. Activities are made to fit the handicapped child and real growth and education take place, so that by the time he is ready to compete with the normal, a consciousness of ability, in spite of handicap, is there; a self-reliance has been established; fear and inferiority complexes have been banished. Moral courage and enthusiasm have built up a resistance. Leadership has developed morale.

He is taking part in all activities. His games, his dramatics, his spontaneity, and self-expression are unlimited. He no longer sits out on account of a physical handicap. He

loses all consciousness of this difference, for it is placed in the background, he realizes others are handicapped—some more than he is. Some one else needs his help, so that he is no longer always the dependent—but he has his opportunities to help others, and independence is emphasized through this ability.

Special training in activities leading to a later vocational training can be emphasized and adapted to the group. Rhythm, folk dancing, and singing games take on a new meaning when one sees them adapted in a group of crippled children. The shining eyes and happy faces bring to these activities the age-old pleasure, enjoyment and love.

Muscle reëducation becomes a vital subject when every child in the group is interested in the new movement of a paralyzed limb, in a controlled spastic arm, or the first steps of a child who has never walked. Every child brings to the one attempting the new action the enthusiasm, earnestness, and interest of the whole group, so that more is attempted and more accomplished. When Mary is able to make a mark that looked like a letter, not only Mary, but her whole class is proud. When Jane stands alone, every one from first to eighth grade is told.

A child is stimulated and encouraged by the admiration and approval of fellow schoolmates. Of course he wishes to please the parent and the teacher, but the children are his world and there is a difference in the desire to stand well with the group and excel in the classroom. A poise and self-reliance are attained in spite of crooked legs or useless hand. The constant supervision by both the staff and the children of the group means conscious effort and development of every part to its fullest efficiency. Only through segregation and carefully selected staff personnel can this be attained. Patience, enthusiasm to try new ways of making routine and weak efforts stronger, kindness, sympathy but not pity, and patience, more patience, as well as a sincere belief that it is worth doing, are required on the part of the instructors.

Can the consciousness of physical handicap be overcome? The children of the Indianapolis School for Crippled Children presented a May Day program. Every child in the school took part. The play was given on the stage in the Auditorium. Over 500 (normal) children and 200 adults were present. The play was based on the year's work in muscle reëducation through folk games, rhythms, and music interpretation. In spite of wheel chairs, braces, crutches, casts, kiddy cars—at no time was the audience conscious of handicaps. Why? Because the children themselves were absolutely unconscious of any handicap and had the poise and confidence to carry it over, for they were living and feeling the thrill of their first public appearance. Their faces were beautiful and happy—no one was conscious of crooked backs and twisted feet.

Will these children be satisfied to sit on street corners and whine and beg? Are not these crippled beggars the product of the time when there were no special schools and handicapped children gave up and lost poise because they were objects of ridicule and pity?

The establishment of special schools has spread through the nations. The success of these schools repudiates the criticisms against segregation. Visit them and be inspired by the atmosphere of happiness, of unselfishness, and the uncomplaining acceptance of handicaps that appall the normal adult.

Some Specialists

Mary M. Marvin, R.N.

STUDENTS, and those who have had other association with Mary Marvin, inevitably think of her first, not as an instructor in nursing education, but as a specialist in the nursing care of the patient. This is easily understood because the improvement of that care is the final end toward which all of her unusual energies have been directed.

MARY M. MARVIN R.N.

Miss Marvin has built up an enviably broad and sound foundation in the art of nursing; she has learned about the sick and their needs from first-hand study and experience. After spending two years in academic pursuits at the University of Minnesota, she entered the school of nursing in that same university, graduating from it in 1912. Then came a year as head nurse at the Columbia Hospital in Los Angeles, and another as supervisor of operating rooms at the Seaside Hospital in Long Beach, California. Some of her most valuable experiences in nursing came to her during four years of private duty which followed. In 1918 she went to the Vassar Training Camp as an instructor. A year later she did postgraduate work in mental nursing at Bloomingdale Hospital, White Plains, N. Y., and, in the same year, received the B.S. degree from Columbia University. From that point she has gone wholly into the field of teaching nurses to nurse—first at the Lakeside Hospital in Cleveland, where she spent the two years from 1919 to 1921; then at Simmons College in Boston for five years, where she was first an instructor and later an assistant professor in biology and nursing; and since then at Teachers College, Columbia University.

During the first two years of this period at Teachers College Miss Marvin also directed the clinical teaching and supervision at Bellevue Hospital—a most happy combination of enterprises, since each could so well throw light upon the problems of the other, and the scope of both be broadened thereby.

Supervision has never meant anything but teaching to Miss Marvin,

and it is in this field that she has made greatest use of the imagination which is one of her biggest assets. She has not only tried out and proved the merit of existing methods of ward teaching, but she is constantly on the alert to see further possibilities in that field. But perhaps of most lasting value is her ability to stimulate others to see the opportunities for supervisors and head nurses as teachers in the ward situation. For of course the surest way of improving the nursing care of the patient is to improve the methods of teaching nursing on the wards. To this end also she has done pioneer work in developing staff education.

Since 1928 Miss Marvin has given full time to teaching at the College and to directing the field work of the graduate nurses who are students in the supervision and head nurse courses there. Her classes in the Teaching of Nursing Practice open new avenues to her students. They are more than classes in the methods of teaching the subject, for she insists on seeking out the relationships between nursing practice and the basic sciences, and on setting up standards whereby these practices may be judged. Probably she has had more to do with stimulating the study of the rationale of nursing measures and of comparative nursing than any other one nurse in this country.

One of the most interesting projects which Miss Marvin has helped to develop latterly is the course for head nurses which combines classes at Teachers College with experience in one of several New York hospitals. This program is planned to give to head nurses, since they are nearest to both patients and student nurses, the help they need in order that patients may have the very best care, while at the same time student nurses may receive the most intelligent and skilfull teaching and direction. In carrying on these courses, as in the supervision courses, Miss Marvin goes to the wards in which the graduate nurse students are having their field experience and together they work out plans for carrying on a program of ward teaching and administration. Nothing could be of greater benefit to head nurse, student, or patient, than such combinations of theory and practice. It would be interesting to know how many patients have received more intelligent care and how many student nurses have a truer comprehension of what nursing really is, because their teachers, supervisors, or head nurses, have been in direct or indirect contact with the philosophy which Miss Marvin exemplifies.

As a member of the National League of Nursing Education Miss Marvin has done much service in helping on the activities of that organization, notably as chairman of the Subcommittee on the Duties, Qualifications, and Preparation of Supervisors and Head Nurses. She has also made valuable contributions to nursing literature.

And yet a recital of her professional preparation and activities cannot begin to give a picture of the real Mary Marvin. She is without doubt one of the most brilliant teachers of nurses in our country. She has an exquisite sense of humor. She knows how to play! She has an inexhaustible fund of energy and enthusiasm. And above all she does not spare herself in bringing all of these gifts to help in furthering our professional program, whose chief functions she herself says are, "Helping a student to be a nurse, and teaching the patient to get well and keep well."

Editorials

Plans for a Brilliant Biennial

HOW many of the American Nurses' Association's 85,000 members will attend the Biennial in June? Six thousand are expected in Milwaukee but, whatever the number, it will not dismay the Wisconsin nurses nor the Program Committee. Long and carefully have the nurses of the Badger State planned for the comfort and happiness of their guests. Housing facilities are adequate and the great auditorium will accommodate all meetings under its spacious roof.

The program, an outline of which appears elsewhere in this issue, has been planned with unusual care. It is focussed on the care of the patient. Four extremely interesting joint sessions have been provided, such as that devoted to the Function of the Registry, the Hospital and the V. N. A. in Nursing the Community. All of them may be expected to broaden horizons in a new and significant way for those whose work has been limited to one field only.

The very name of Dr. Glenn Frank, President of the University of Wisconsin, who will be the speaker on opening night, carries inspiration with it. While inspirational in the best sense and concerned with large movements and broad policies, the program makers have provided for carefully detailed discussion of practical problems. The American Nurses' Association, for example, is planning for two round tables on Registries. At one the problems of administration as related to registries will be discussed, at the other the problems of the individual whose professional life is dependent upon the registry will be the theme.

The League, stimulated by the studies on the Grading Committee, is providing conferences on such basic problems as the "Need for Standardization of Records," the "Selection of Students," the "Administration of Affiliations," and "Supervision."

The N. O. P. H. N. is equally concerned to provide both inspirational and practical assistance.

An entire afternoon devoted to observation of nursing procedures in Milwaukee hospitals is an exceedingly attractive innovation.

An exposition of broad scope and sound educational value is being planned. It will be by far the largest yet held in connection with a meeting of nurses.

All told, the prospects for a genuinely stimulating and helpful convention are very bright. Once again, we suggest the value of budgeting time at the convention. Plan with care for the meetings that interest you. Plan well in advance for conferences with those whose advice you would seek. With a rich feast set before the nurses of the country, they will have only themselves to blame if any "go empty away."

International Congress on Mental Hygiene

ALL who have a serious interest in mental hygiene will be welcome at the International Congress on Mental Hygiene to be held in Washington, May 5–10. The Committee on

Programs is headed by Dr. Frankwood Williams, Medical Director of the National Committee for Mental Hygiene. The Advisory Committee on Programs has representatives from thirty-seven countries and eleven allied groups. Effie J. Taylor, Professor of Psychiatric Nursing, Yale University, represents nursing.

The general program, as outlined, is comprehensive. As is the custom at such meetings, the papers will be printed in various languages. Digests, only, will be presented from the floor, thus permitting ample time for the discussions in which some eminent nurses are invited to participate.

Generous provision has been made for round tables and at these some stimulating problems will be thrashed out. Miss Taylor and a committee of nurses are actively at work completing programs for round tables dealing specifically with nursing problems. Representatives of nursing in other countries are expected. Some of the nurses whose professional interest centers in psychiatric nursing or in some phase of mental hygiene may find themselves in the dilemma of having to choose between the International meeting in May and the biennial meeting of the nursing organizations in June. If both cannot be encompassed it seems probable that the specialists will choose the Washington meeting.

Hospital Day—A Day of Enlightenment

THE author of two recent and widely read mystery stories chose hospital settings for her lurid plots. So vivid were the stories to her that when she again became a hospital patient it is said she required her special nurse to sit between the bed and the door! Few people have any such grisly associations with hospitals but many are sadly uninformed about their organization, their service, and their costs.

To overcome this lack of understanding Matthew O. Foley, Editor of *Hospital Management*, inaugurated National Hospital Day in 1921 and chose Florence Nightingale's birthday for the day of enlightenment. The plan became so instantaneously successful that the magazine generously referred the whole matter of leadership in planning celebrations to the American Hospital Association. That Association now is prepared to assist hospitals, large or small, at home or abroad, with specific suggestions for their programs.

Nurses have a many-sided interest in hospitals. They can add much to the effectiveness of the programs. It is important that they shall lend every possible aid to ways and means of presenting facts about hospitals and their various services, curative, preventive and educational, in the clear light of reason and of understanding.

Nurses are in closer contact with the 10,000,000 patients who are cared for annually than are any other group of workers. They have a marvellous opportunity for promoting understanding. This can be done not only by celebrating Hospital Day but by disseminating sound information on hospitals and on nursing throughout the year.

Grading—and the States!

THE reactions of individuals and of groups to the returns from the Grading Committee are interesting and revealing. Naturally, the moment the figures on the education of student nurses appeared in the February *Journal*, discussions and comparisons began. In some instances, the finest qualities of sportsmanship were revealed. Taking a clear-eyed

professional view, such nurses decided that, although students might have made errors in filling out blanks, the tendency to error might be expected to be more or less uniform. In other words, they decided that if students in Chicago, or Cincinnati, or Cleveland made errors, probably students in other cities did the same. A ranking of the figures, therefore, they believed would still be as accurate as it would be possible to make it without extremely costly checking and rechecking.

The nurses in one of the states which has a particularly bad showing have our unbounded admiration. They had known that conditions were unsatisfactory but they were profoundly shocked when shown just how bad their educational status is. Their low rank undoubtedly is due, in part, to low educational standards throughout the state, for conditions in the public school system there are not of the best. This fact might easily have been used by the nurses as an alibi, but not so! Swiftly upon the publication of the figures the State Association swung into action and issued a call for a meeting of the district presidents. The State Board of Nurse Examiners was consulted, the coöperation of the State League sought. Squarely the facts were faced. Plans were formulated for carrying data on nursing to the vocational advisers in the high schools. Other plans are in the making.

Those nurses were dealt a stinging blow but they have taken it standing. They have wasted no time in commiserating themselves. They are off to a new start. Data in hand, they are securing assistance from those in a position to give it. And that, we suspect, is the measure of the worth of a fact-finding organization like the Grading Committee.

What a Registrar Said

"YESTERDAY we had 296 nurses on call and 57 calls to fill." This was a fairly typical mid-winter picture of that city, and it was paralleled, more or less, in many another. During an interview with the registrar all of the usual registry problems came up for discussion. The unusual feature of the conference was due to the fact that the registrar who had once been director of an important school of nursing had changed her viewpoint. The school, located in a hospital of rich and varied services, had classes limited only by the capacity of the nurses' residence, not by the law of supply and demand in nursing.

A question as to the wisdom of enrolling ever larger classes brought the swift reply:

> I used to wonder what happened to my lovely young graduates. They left the school full of idealism and altruism. They believed the world was theirs. So, in the main, did I. Many of them joined this registry. Then began the weary wait for cases. Enthusiasm, altruism, spontaneity faded in the struggle for existence. Now I know what I did not grasp when I was under the compulsion of providing nursing service for a hospital. I know that it is wrong to operate a school on the basis of the need of the hospital. I know that a school should be operated on the premise that it is preparing nurses for a place in the world. The school should be expected to provide only a part of the hospital nursing service.

The obvious next question was: "If you were offered another position as director of a school of nurses, under what conditions would you accept?" It was clear that the question had been in her own mind for again the answer, clear cut, definite, thoughtful, was ready. In substance it was:

> Never again shall I accept the direction of a school of nursing unless the number of students is definitely limited, as the number of students in a medical school is limited.

Never again shall I attempt to carry the nursing service of a hospital on the basis of its student service alone.

The nursing service should be one thing, the school another. The nursing service should be planned on a basis of graduate service and attendant service supplemented by the very valuable service of the young women learning to nurse; namely, the students.

Probably the whole system of educating nurses would be altered if all superintendents of nurses could be responsible, for a time, for the placing of graduates, and if those on the outside of the schools could know the serious problems that daily confront the directors of the schools.

Superintendents of nurses, alone, are powerless to change a system so rooted in the complex economic situations in hospitals. Private duty nurses are called to the homes of members of the Boards of Trustees. Armed with such facts as may be found in *Nurses, Patients and Pocketbooks*, guided by tact in the manner of presentation, private duty nurses could do much to improve the unsound economic basis of schools of nursing and of their own specialty.

The International Nursing Review

BY action taken at Montreal, "*The I. C. N.*," with the January number, became the *International Nursing Review*. It is to be published every two months instead of quarterly and the subscription doubled. It is now two dollars per year, an amount easily mailed in bills to the Headquarters at Geneva.

In appearance and in content the magazine is a credit to the editor, Christiane Reimann, and to the Council. It is worthy of the respect of the nurses of the world. Sister Bertha Wellin, member of the Swedish parliament, who is Chairman of the Publications Committee of the International Council of Nurses, says in an editorial foreword:

One of our aims must be that the subscribers to the *Review* in future include all the larger hospitals and other institutions dealing with nursing education in every country where a member of the Council is in existence. Not until this is achieved will this message to the nurses of the civilized world fulfill its task of maintaining contact between the hundreds of thousands of women of all races who wish to continue the work begun by Florence Nightingale and to serve her ideals.

We heartily concur. Student nurses cannot too early become familiar with the invisible but tenacious spiritual bonds which bind together the nurses of the world, nor can graduates fail to enjoy the consciousness of a kinship that girdles the globe.

Ethical Codes

EVERY profession has an ethical code. It cannot live and work without one; but that code should protect all concerned, not just one's own group interest. If you have a human tool, use it, but don't use it up. Service and human labor are not mere economic commodities. Don't ask people to sacrifice themselves forever. In your profession's code of ethics there must be something that protects the worker and the fellow-worker, the patient and the public. When difficulties face you, look to your code of ethics; and also remember that the pay you receive is partly in money and partly in human satisfactions. The returns for your services run in a series from A to Z. Those from A to M you can buy with money—and you have to have some money; but those from M to Z no money will ever buy. Be sure you collect both kinds of satisfactions and not merely one. And do not forget those rewards that come from the way you do your job.—Dr. Henry Suzzallo, "Social Aspects of Specialization and Coöperation in the Health Field," *Nursing Education Bulletin*, Teachers College, New York City.

Walter Burns Saunders Memorial Medal

SAUNDERS' MEDAL

SAUNDERS' MEDAL, REVERSED

A MEDAL fashioned after the beautiful and dignified design shown above is offered by W. L. Saunders, II, of Philadelphia in memory of his father, Walter Burns Saunders, as an award for an outstanding service to nursing rendered by an individual nurse.

This award will be made at biennial conventions of the American Nurses' Association, the first to be presented being given this June during the biennial convention in Milwaukee. The choice of that individual whose name is to be marked above the words, *Distinguished in the Cause of Nursing*, will be determined, according to the report made to the A. N. A. Board of Directors in January, as follows:

> The recipient of the award, according to the wishes expressed by Mr. Saunders, is to be a nurse who has made to the profession or to the public some outstanding contribution, either in personal service, or in the discovery of some nursing technic that may be to the advantage of the patient and to the profession. The only kind of service excluded is that of writing.

Eligibility

ANY nurse who is a member of the American Nurses' Association, and who has made to nursing some such contribution as already described, is eligible for the medal.

Recommendations

THE name of a nurse recommended to receive this high honor may be submitted by a state association or by individuals. Recommendations should be submitted to A. N. A. Headquarters, to the president of one of the three national organizations, or to Mr. Saunders. The recommendation should state accurately the nurse's name, her address, her official position. It "should carry with it," stated the A. N. A. Board of Directors, in January, 1930, "a complete statement of the professional background and accomplishment of the individual, together with a history of the achievement for which the award is to be made."

Our Contributors

Dr. E. J. Anderson is credited with saving many lives, through his service as interne at the Saginaw General Hospital during the last year's epidemic. He is now a practicing physician. **Martha L. Riedel, R.N.**, Superintendent of Nurses, writes glowingly of the splendid coöperation of hospital trustees, city health department, central laboratory, and the nurses' registries.

Dr. James R. McCord is on the faculty of the Department of Obstetrics, Emory University, Atlanta, Ga.

Martha Ruth Smith, R.N., B.S. (Peter Bent Brigham Hospital School of Nursing, Boston) has been Director of Theoretical Education at Massachusetts General Hospital and is now a part-time member of the faculty at Teachers College.

Ellen L. Buell, R.N., B.S. (Faxton Hospital School of Nursing, Utica, N. Y.) is Educational Director of the Henry Street Visiting Nurse Service, New York, where she has unusual opportunity for utilizing the case-study method in her teaching.

Hester Viney, S.R.N., Lecturer, College of Nursing, London, England, is a graduate of the Nightingale School, St. Thomas's Hospital, London, and holds an imposing array of certificates and diplomas, including the certificate of the Central Midwives Board and the diploma in "Elementary Economics, Sociology and Hygiene in relation to the duties of Public Health Nurses" (University of London).

Mrs. Nan Ewing, R.N. (St. Louis City Hospital School for Nurses) had a graduate course in obstetrics at the Chicago Lying-In Hospital, and was Obstetrical Supervisor at Mt. Sinai, Cleveland, before becoming Principal of the Ravenswood Hospital School of Nursing, Ravenswood, Ill.

S. Lillian Clayton, R.N., as many know, acquired her knowledge of administration at Miami Valley Hospital, Dayton, Ohio, the Minneapolis City Hospital, Cook County, Chicago, and the Philadelphia General Hospital where she is Directress of the School for Nurses.

Those who read "between the lines" of the article on Federal legislation will have a vivid picture of the heavy burden of responsibility borne by some of our national officers. The unpaid service of such women as **Clara D. Noyes** is beyond reckoning.

"Rembrandt" is the final article in **Brooke Peters Church's** series on "Hidden Sources."

Jennie C. Quimby, R.N., is one of the faculty of the Tennessee Coal, Iron and Railroad Company Hospital School at Fairfield, Ala. She collaborated with Miss Dock in revising Dock's *Materia Medica*.

Virginia McCormick, Publicity Secretary of the American Nurses' Association, provides some practical suggestions at the psychological moment when they are needed.

One by one, the schools of nursing of the Sisters of Providence enlarge their programs and their equipment for teaching nurses under the wise leadership of **Sister John Gabriel, R.N., B.S.**, Educational Director for Schools of Nursing of her Order.

Mary F. Wallace, R.N. (Lakeside Hospital School of Nursing, Chicago), who has had eight years of public health work and more than twenty-six years of private duty nursing, says that she has often been "weary in my work, but never weary of it."

Mrs. Mae L. Whitford, R.N. (Proctor Hospital School of Nursing, Peoria, Ill.) has had a varied nursing experience. She is anesthetist for the Collins Clinic, Peoria, Ill.

Mathilda L. Johnson, R.N., is Supervisor at Large of Nursing for the Metropolitan Life Insurance Company, with headquarters in Chicago.

It was great good fortune that **Alice Fitzgerald, R.N.**, could so quickly follow her article on "Nursing in Italy" (March *Journal*) with "Joyful News from Florence."

Ethel C. Scofield, B.Sc., is Physiotherapist at the School for Crippled Children, Indianapolis.

Pearl Castile's valuable study is worthy of the thoughtful attention of every nurse educator.

Mary A. Rothrock, R.N., Superintendent of Clearfield Hospital, Clearfield, Pa., is President of the Pennsylvania League of Nursing Education.

Anna Hyman and **Ruth Dreyfous,** psychologists of New Orleans, made the study on which their paper is based under the direction of Professor Louis Wirth, Department of Sociology, Tulane University.

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

Contribution to the Education of Nurses Made by a Study of Normal Children[1]

PEARL I. CASTILE, R.N.

Judging the Effect of the Course on the Quality of Nursing Care

TO analyze and to measure the influence of this course was one of the objectives of this study. At the close of the course in "Preventive Pediatrics" the students taking the course and those in the control group were again judged by the "Standard for Judging the Influence of Course 'Preventive Pediatrics.'" These ratings were again made independently by the supervisors and their assistants, so that each student again had two ratings. To compare

TABLE II—RESULTS OF RATINGS

Group Taking Preventive Pediatrics				Group—Control			
Student	Average of First Rating	Average of Second Rating	Gain in Points	Student	Average of First Rating	Average of Second Rating	Gain in Points
1	109	112	3	1	109	115	6
2	101	115	14	2	99	105	6
3	99	107	8	3	99	103	4
4	98	110	12	4	98	98	0
5	96	110	14	5	98	105	7
6	96	106	10	6	96	105	9
7	90	92	2	7	87	96	9
8	85	100	15	8	83	82	−1
9	84	96	12	9	82	88	6
10	84	100	16	10	81	89	8
11	78	91	13	11	79	88	9
12	78	94	16	12	78	78	0
13	77	87	10	13	77	86	9
14	76	96	20	14	76	76	0
15	70	96	26	15	69	78	9
16	65	85	20	16	64	69	5
17	64	89	25	17	64	62	−2
18	62	75	13	18	55	59	4
Total	1,512	1,761	249	Total	1,494	1,582	88
Average	84	97.8	13.8	Average	83	87.8	4.8

[1] Continued from the March *Journal*.

the results the accompanying graph (Graph I) indicates the improvements in each group. These two groups with approximately the same average score by the first rating, 84 and 83, show a considerable difference in the second ratings. The first group with an average score of 84 after a study of normal children averaged a score of 97.8 or an average gain of 13.8, while the control group beginning with a score of 83 now showed an average score of 87.8 or an average gain of 4.8.

These ratings are based upon the judgments of supervisors and, therefore, are modified by the personal element. The excellent qualifications of the supervisors reduced this source of error to a minimum. With the decided difference in the second ratings of the students showing a gain of 13.8 in points against a gain of 4.8 in the control group, it seems safe to say that a part, at least, of this improvement may have been due to the influence of the course in "Preventive Pediatrics."

In checking the individual items, it is noted that the improvements made by the control group were in points which have to do with the mechanics of nursing, the so-called general nursing care. Examples of points in which this group improved most are as follows:

1. Have therapeutic treatments been given when needed?
2. Has food been given when needed?
3. Have the surroundings been untidy?
4. Has her work been finished?
5. Has good technic been observed?

The group which studied normal children not only improved in these items but, also, in nursing points which indicate a sympathetic consideration of the personality of the child. Examples of these to which I refer are as follows:

1. Has the child been made happier by finding his interest?
2. Have changes been noted in mental attitude or behavior of the child?
3. Has the child been hurried?
4. Has the procedure been adapted to the child?
5. Has an explanation of treatment been made?

The supervisors expressed their conviction that the study of the normal child influenced the behavior of their students. Below are several comments made by the supervisor under the heading "Remarks":

1. "Miss S. is able to make the children much happier."
2. "Miss D. is particularly interested in Preventive Pediatrics and the quality of her nursing is improving."
3. "Miss L. is showing great interest in children and does many little things to add to the child's happiness."
4. "Miss K. always works for the best interest of her patients. Tries very hard to help the individual to adapt himself to situations."
5. "Mrs. F. is more mature than the average student. Always comparing the normal child with the ill and trying to help the child become more nearly normal."

Following are some comments made about the students in the control group:

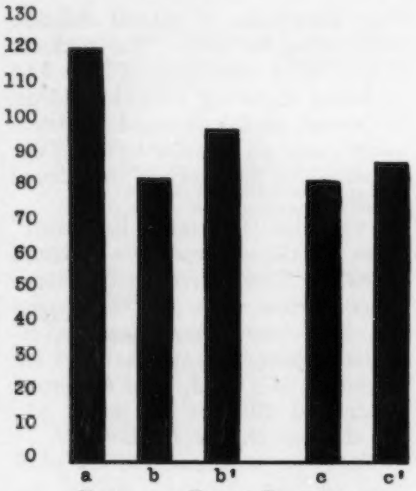
1. "Miss J. has been a school teacher. Manages children very well."
2. "Miss F. does not like children."
3. "Miss C. at times becomes rather impatient with children."
4. "Miss H. shows little interest in the individual child."
5. "Miss K. has shown no improvement in the quality of her work."

It is not to be assumed that the course in "Preventive Pediatrics" was the sole cause of the improvement noticed in the quality of nursing. The able supervisors who direct the nursing in these departments of Pediatrics and Communicable Diseases have been a large factor in the development of these students.

Conclusion

THIS experimental study has attempted to show that a study of the normal child, generally accepted as desirable, can be carried out in practice without interfering with the work of the hospital wards. Facilities, such as public schools, which are near at hand can be utilized. The additional class work does not prove a burden because the students assigned to the specialties of pediatric and communicable disease nursing have ordinarily reached a period in their training when their classes are few. That other students asked permission to take this course is an indication that it is not a burden. These requests may show, also, that these students felt the need of such study.

As to the ultimate values in the study of normal children for the education of the nurse, it will be necessary to observe these young women for a longer period of time and to secure their opinions later on as to the worth of such a study. It seems safe to say, however, that a study of normal children places the emphasis on health. It teaches the nurse to be a more sympathetic observer. It teachers her to accept the responsibility, not only for the physical deviations from the normal but also the serious responsibility for the mental health of the child. From a study of the personality of each child and the environment in which the child lives, she gains a better understanding of the child as an individual. With better understanding of the child comes a personal interest in his welfare and as a result, more intelligent nursing care. It is hoped that this course has given to students of nursing a realization that



RESULTS OF RATING STUDENTS

a—Perfect Score
b—Average Score of 1st Group (1st Rating)
b¹—Average Score of 1st Group (2nd Rating)
c—Average Score of Control Group (1st Rating)
c¹—Average Score of Control Group (2nd Rating)

GRAPH 1

It is of paramount importance to recognize the beginnings of undesirable habits which are likely to twist and warp the individual's personality, and to institute treatment at a time when it will be most effective and serve best both the individual and society.[2]

Summary

A QUESTIONNAIRE was sent to fourteen schools of nursing to determine the provision made for students of nursing to study normal children. Eight schools offer such experience and three of the remaining six are now planning for such work. There is wide variation in the character of the opportunity provided for this experience.

The hours devoted to the study of normal children ranged from 0 to 96. Nursery schools, well-baby clinics, and well-baby wards were used to provide this experience. Four of the eight schools give from 50 to 96 hours to this study. Their students acquire

[2] Thom, '28, p. 44.

their knowledge of normal children while caring for them. The students of four other schools spend from 2 to 12 hours observing normal children. No school, as far as could be determined, used an organized plan of observation for the study of the normal child.

The course "Preventive Pediatrics" given to the students of Highland School of Nursing included eighteen hours of class work and conferences and five observations based on organized plans, one of the home environment of a child, three of normal children at different age levels, and one of a sick child in the hospital.

Thirty-six students from the pediatric and communicable disease departments of the hospital were rated according to a standard. This standard gives a possible score of 122. Eighteen students, with an average rating of 84, enrolled in the course. Eighteen students of approximately equal ratings, average 83, were observed as a control group. A second rating of all students was taken upon the completion of the course. The rating of the group taking this course averaged 97.8 or an average gain of 13.8, while the control group gave a mean score of 87.8 or an average gain of 4.8.

The improvements made by the control group were largely in points which have to do with the mechanics of nursing, the so-called "general" nursing care; while the group which studied normal children improved not only in those points but, also, in nursing points which indicate a sympathetic consideration of the personality of the child.

The results of this study indicate that it is practical to provide an opportunity for students of nursing to study normal children and that such a study improves the nursing care by developing a sympathetic understanding and appreciation of the personality of the child.

Example of Written Report of Home Visit

Observer: G. Young.
Home of child visited: J. P.

I. *Residence*

Type: House was a modern bungalow, one floor.

Location: East Oakland.

Neighborhood: Residential district. Good neighborhood surrounded by modern homes. Quiet and clean.

Yard space: A large yard was inclosed by a high board fence. The front yard was medium-sized and well kept.

Rooms: There were six rooms with a bath. The rooms were light and airy and each was approximately 14 x 14 feet. There were large windows in each room allowing for fresh air and sunshine. The living room and dining room were heated by fireplaces and the kitchen by a gas and wood range. The three rooms in which the family spend the evenings were comfortably warm, with the plain and simple furnishings of necessity. Apparently the family income was small, but they were making the best of what they had. The rooms were well cared for. The bedrooms were clean and simply furnished, with windows open. The bathroom and kitchen also were very clean.

Noise: The children were playing quietly and laughing. There was no confusion nor uproar in the home.

II. *Parents*

Only one parent was observed. The mother was a healthy, wholesome appearing middle-aged woman. She seemed happy and was much concerned about her children. She seemed very tired. Her children and her home seemed first in her mind. She had separated from her husband and, from the information given to us, we learned that he drank heavily and wasted his money. The parents were Italian, the mother speaking very broken English. At times, the children interpreted for us. This mother appeared to be that motherly type whose chief interest is that of making a comfortable, happy home life for her children.

III. *Children*

There were five alert and happy children, three girls and two boys, ranging in ages from five years to sixteen years. The

oldest boy worked to help support the family. All these children were well nourished, healthy looking children with bright eyes and curly hair. They were dressed comfortably and in simple style. All the children were in school grades indicative of normal progress.

The children responded courteously and quietly to visitors. The smallest girl, when called upon to sing for us, did not hesitate, but sang three little songs.

The older children helped their mother by clearing the table, washing the dishes, and sweeping the floor following the evening meal, which they had just finished.

A small crystal radio set with ear phones was the chief amusement for all of them, but this they used in turn with no confusion or quarreling. Other playthings, as a doll, a puzzle, pencils and paper, were evident. No doubt we were shown all that they possessed.

Conclusion

The advantages, I believe, of this home are (1) an interested mother who makes the home life happy, (2) five children in the family will help to develop their independence, unselfishness and kindness to others, and (3) the home, itself, is conducive to health.

It would seem advisable, however, that these children be provided with books, with more constructive play materials, with outside contacts. They should have more opportunity to develop their creative abilities.

The oldest boy should be guarded against assuming the father's place as wage earner and thereby having no time for leisure, play, and a chance to develop his interests.

However, this mother with her interest in their welfare, will provide a happy home for them and this will do much to further their development.

Example of Written Report of Observation of a Normal Child

Observer: A. C.
Code name of child: S.
Age of child: 3 years, 4 months.

General Characteristics of the Age Level

Physical:
- Average weight: 30–31 pounds without clothes.
- Average height: 36–36⅝ inches without shoes.
- Teeth: first set, or twenty milk teeth.
- Muscles: Grow rapidly. Movement elaborate. Jump, skip. Spine strengthening.

Mental:
- Speech: 500–1,500 words in vocabulary. Two-word sentences. Pronouns, I and you, are used.
- Asks "what."
- Calls things and animals.
- Likes to imitate.
- Emotions easily disturbed. Easily moved by sympathy and affection.
- Learns results by association of experiences.
- Imagination developing.
- Tears from grief—not alone from anger or annoyance.

Social:
- Dependent upon adults.
- Slight amount of play with other children.

Individual Study

I. Environment:

A. Situations: Large playground and equipment provided. Weather changeable. Sun and clouds. Shade from a number of trees. Three or four directors on the playground.

Inside: Large house with fairly high ceilings. Sunlight from the windows. Well ventilated. No glare.

Equipment:

1. Playground: slides, poles for climbing, steps, sandbox, saws, wood, paints, balls, boxes, wagon, tricycle, doll buggy, chairs, benches, bricks, boards, cloth, aeroplane.

2. House: Desk, paper, charts, pictures, blocks.

3. Advantages: These serve to develop equilibrium, balance, coördination, imagination, imitation, manipulation, creative powers.

B. Group Activity: All played together while flying an aeroplane. They listened attentively to a director and then took turns flying the plane.

II. Bodily Equipment of S.:

Organismal functionings: Well developed muscular coördination. Steady gain in height and weight. Good circulatory adjustment. No digestive disturbances. Tendency to respiratory infections.

Hair: Plentiful with lustre.

Eyes: Bright and clear—no squinting.

Unobstructed nasal breathing: Mouth closed while playing. Mucus from nose probably due to upper respiratory infection.

Teeth: Appeared in good condition.

Color of skin and mucous membranes: Ruddy pink. Lips pink, nails pink.

Quality of skin: Moist, clear, soft and smooth.

Subcutaneous tissue: Firm.

Muscles: Apparently well developed for age.

Shoulders: Squarely built.

Arms and legs: Long bones were straight.

Feet: Arches well developed.

Chest: Old rickets with slight deformity.

Weight: Average for age. Steady gain in both height and weight.

III. Organismal Functioning:

Alert, happy expression.

Tongue, moist and red.

Posture, good.

Indulges in vigorous muscular play and handles material easily. Good coördination of muscles. Falls down easily if pushed.

IV. Traits of the Child:

Eating: Per diary record. Took small amount of spinach on fork. Held fork between lips after each mouthful. Filled mouth so full of sandwich that he could not eat it. Uses his right hand.

Speech: Connects two and three words to form sentences. "Me too," "Me play too," "Awite." Enunciation not clear, but improving.

V. Diary Record:

First five minutes: Played with toy machine. Wheels it. Looks at wheels. Watches aeroplane which was being flown. Puts hands up for plane. Tries to manipulate plane. Loses rubber. Unable to fly plane. Sits down on table with hands folded. Watches others.

Second five minutes: Grabs tomato juice in both hands. Drinks. Runs back to plane. Hunts plane in bushes. Lets other hunt. "Couldn't-be-bothered" attitude. Grabs plane from attendant. Manipulates plane for the first time by himself. Plane lost in trees. Looks on. Grabs tray on table where tomato juice is being served. Turns tray upside down, spilling napkins on the ground. Watches director out of corner of eye. Teasing look as director asks him not to do it. Picks up napkins. Puts them in waste paper basket.

Third five minutes: Climbs over pipe. Pulls at drain pipe on house. Straddles pipe, sits and watches others. Puts finger on screen of small window. Says, "See man," imitating another child. Pulls at the drain pipe. Throws clods of dirt through the hole in side of house. Walks along pipe holding to wall to balance. Watches others. Pushes another child away, but withdraws when other child strikes back.

Fourth five minutes: Grabs handle of wagon and pulls with own initiative. Pulls child in wagon. Says, "Get out," to child. Pushes other child. "Me come back at 8 o'clock." Walks around playground. Comes back to child again pretending to come back to station. Puts small toy trains in wagon. Says, "Get out, too heavy, you push." Drops wagon. Runs with other child to collect tin pans and to play house in box. Climbs on boxes and walks up steps. Collects trains, spoons, tin pans, machines into one pile.

VI. Comparison:

Physical: This child was 11 pounds underweight for height when he entered the nursery, but steadily gained until he became the average for the age. His muscular development is average for his age. He jumps, skips and coördinates well.

Mental: This child is average in intelligence for his age. He uses two or three word sentences, uses pronouns. He has imagination, imitates and asks many questions.

Social: S. showed particular affection for one small girl. He has the characteristics of his age level in that he does not play with other children to any great extent and he prefers the attention of adults.

VII. Recommendations:

Health: His weight must be watched carefully for he is so active, his play tends to keep him from eating or hurries his eating. Longer periods of rest before eating might serve to quiet him.

The respiratory infections should be cleared up and the foci of infection found. Plenty of sunshine to aid his development is necessary.

Environment: His home environment has been chiefly with adults and this probably accounts for his dependency upon adults. The nursery school and his association with other children will undoubtedly benefit this child.

He appears to give up easily with a "can't-be-bothered" attitude which may be due to the help he has received from the adults.

It would seem valuable that he be placed, as he is in the nursery, with children of his own age and there be allowed to fight some of his own battles.

This child comes from a home in which the parents are interested in doing the best for this child, but he has been made dependent because too much has been done

for him. These parents realize the child needs other children for associates, and so have placed him in this new environment which will help him develop physically, mentally and socially.

EXAMPLE OF WRITTEN REPORT OF OBSERVATION OF SICK CHILD

Observer: L. B.
Place: Highland Hospital Ward.
Child: J. S.—9 years.

Characteristics of Age Level

Physical: Growth is rapid, especially growth of arms and legs. They have more speed and strength than gracefulness. Normal average height for age—50 inches. Normal average weight for height—60 pounds.

Mental: This is known as the "Big Injun" age. The children are sensitive. They seek advice and inquire the reasons for things. They ask "why" instead of "what." Many reach their maximum mental growth at this age. They are able to define such words as pity, revenge, charity, and they are able to detect obvious mistakes in paragraphs. They can point out the lessons of fables.

Social: Outside contacts are sought. Gangs are evident and although games are played together, there is still individual feeling of competition present. At this age, children enjoy collecting, drawing, and they are inclined to be superstitious.

Environment: J. was a patient on one of the large wards, in which there were five other beds besides his. There was plenty of air and light in the room.

The only equipment for either play or work consisted of six pennies, one nickel, one dime, and a toy automobile.

There were in this ward, three men and only one other boy, aged fourteen.

Group Activity

There was no group activity. Each patient was occupied in his own way of passing the time during his stay in the hospital.

Individual Study of J.

Bodily equipment:

Hair: Black and glossy.

Eyes: Severe conjunctivitis with a corneal ulcer of the left eye.

Breathing: Apparently unobstructed.

Teeth: Hygiene very poor. Many cavities.

Color of skin: Very pale. Lips dry and cracked. Skin dry.

Subcutaneous tissue: Flabby.

Muscles: Weak and undeveloped.

Shoulders: Slightly rounded forward.

Chest: Flat. Expansion poor.

Arms and legs: Legs showed healed superficial excoriations. Long bones apparently straight.

Weight: J's. weight is 51, nine pounds under for his height.

Ankles: Apparently inner and outer sides equally prominent.

Feet: Arches apparently strong.

Organismal functioning:

J. has a dull, sluggish, somewhat pitiful expression.

Tongue: Dry and coated.

Posture: Poor posture, probably due to illness, lax muscles.

Response: His response is slow.

Bodily repose: Free from constant, unnecessary activity.

Endurance: Easily tired.

Traits of child:

Use of hands: J. uses his right hand.

Speech and gesture: His speech is limited and his gestures slow and somewhat clumsy.

Emotional responses: J. responds when any attention is shown him. He lacks companionship.

Property: Careful of property of others. He has none of his own here, but, I believe, he would care for his own with consideration.

Response to other persons: Wants attention from others. Appears very lonely.

Diary Record:

4–4.05—Walked into hall. Stood by the door. Went back to bed and sat in chair. Went to end of ward and stood while man talked to him. Walked to his own bed and climbed upon it.

4.25–4.30—Played with automobile on the floor. Chased a piece of paper around the bed. Smiled at the other boy and held the automobile for him to see. Sat on the chair and held the pennies. Dropped a penny. Got on the floor and hunted carefully until penny was found.

5–5.05—Walked up and down the hall. Stood near the supervisor's desk. Pushed his glasses up on his nose when told to do so. Went to the door of the treatment room to watch the nurses. Stood by the door of his own ward. Watched children in opposite ward.

5.30–5.35—Climbed into a wheel chair when told he could play with it. Wheeled himself up and down the hall. When told

to put it away, obeyed at once. Wheeled chair into place, being very careful not to strike the wall. Went to the door and stood.

COMPARISON

Physical: J. is far below the normal physically. Since he has been here, however, he has improved very much. He looks like a different child from the one that entered several days ago.

Mental: This child is also below normal mentally. He seldom says a word and it seems difficult for him to speak. He understands fairly well.

Social: J. is accustomed to being alone and is very shy. He never speaks to another child or makes the first advance. He responds to any suggestions made by the nurses.

RECOMMENDATIONS

His treatments of extra nourishment and cod-liver oil seem advisable until he reaches normal weight for height.

His teeth should be cared for and his eye condition carefully nursed.

His home environment should provide opportunities for good hygienic measures to be carried out.

He needs contacts with other children.

He needs play. He seems lonely, lacks initiative and therefore, needs someone to help him develop a feeling of independence.

He needs school work to suit his mental capacity.

It seems that while here we could help this boy by providing simple things for him to play with. He cannot do much that would involve using his eyes but he could do many things with his hands. It seems too bad for him to stand and eagerly watch the busy nurses when a very little time on our part could make him busy and happy. I would also suggest that he be moved so that he would be in the company of other children while here, rather than in his present ward with much older persons.

Reading short stories or telling him stories would be profitable if time could be arranged by the nurses. If the nurses are unable to do it, perhaps another patient would read aloud if a story were provided.

When his present acute illness is over, an out-of-door life would help to develop this boy.

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Some Educational Problems[1]

MARY A. ROTHROCK, R.N.

PROBLEMS in nursing education become daily more complex. No one will question the value of organization as it relates to successful enterprise. Today we come, representing not so many hospitals, not so many factions, but as a group of nurses organized primarily to further the interests of nursing education. It is to this and similar organizations upon which the efforts being made by your various state bodies to enforce maintenance of proper standards in our schools of nursing must look for staunch support if the best interests of the profession are to be served. Since all nursing is so inextricably bound up with our schools of nursing, their future is naturally to us a matter of great concern. Their weaknesses we neglect at our peril. This is logically the task, duty, and responsibility of this and similar organizations and will involve courage and independence to lead the way.

Those who are responsible for our schools of nursing are fully aware of their many defects. Apprehension caused by many obvious failures in

[1] Presidential address to the Pennsylvania League of Nursing Education, October 25, 1929, York, Pennsylvania.

our schools today forms the basis for the earnestly intended and thoughtfully expressed policies of the new *Curriculum for Schools of Nursing in Pennsylvania* which will be presented today for your consideration, its sole objective being an eventual provision of nurses capable of service in its truest sense. In all probability the student of today will be in service twenty years from now. Is there the slightest hope that she may be able to follow in the footsteps of advancing knowledge, unless a considerable portion of her short years of learning be given to the fundamental soil from which this new knowledge will grow? Without this foundation the graduate is left suspended in mid-air instead of standing with both feet upon a ladder which she can climb. The methods and procedures necessary and inevitable in commerce will bring disaster to a profession such as ours.

This presents a problem which today forms the root problem of nursing progress and to which we invite your active consideration, the question of economic independence for our schools of nursing. Without this we must continue to spin in a vicious circle. Altogether it seems apparent that there is no valid argument in favor of a hospital, ill prepared to conduct a school of nursing, continuing its school. Is it not time we ceased sacrificing our ideals and standards for extra pairs of hands and extra pairs of feet (the result of tradition, inadequate budgets and, may I say, inert Boards of Trustees), and give more serious consideration to the type of institution privileged to conduct a school of nursing? If so, how shall the fitness for such an institution be judged? What standards and tests should be applied? If nursing is ever to come into her own, must not her schools be placed upon the same basis as other institutions of learning and be subject to the same supervision? I concur entirely with Miss Wheeler in the hope that, before Dr. Burgess completes her work on the Grading Committee, she may be able to formulate a plan for accrediting schools of nursing making it necessary, before the school is accredited, to have a member of the Board of Trustees appear before an official group, giving definite reasons why their particular hospital is prepared to give women an education in nursing and to grant them a diploma.

Is it not absolutely useless and unfair to all concerned to recommend that schools should do thus and so, when the funds with which to carry on are totally inadequate or entirely lacking? Is this problem solely one for the medical and nursing professions to shoulder; since we are preparing the nurse for public service, is it not reasonable to expect the public to assume a large share of this responsibility as it does in all similar professions? Apropos of this, have we been pressing sufficiently upon the public, their obligation? We have been untiring in our efforts to impress upon the nurse her responsibility to the public—have we in like manner been so tireless in pressing upon the public their obligation to the nurse? Do they not owe her a better education for the service which they expect her to render? If our schools of nursing are to be educational in their truest sense, if nursing is a profession, why is it alone of all professions, outside of university control? Just as education has helped in various other endeavors, so will a generalized education remedy misunderstandings and inadequacy regarding matters pertaining to nursing.

Are we doing as much as we should in an organized way to create a better understanding with hospital trustees

and the public concerning our problems and their obligations? Have we sufficiently stressed to our hospital trustees the responsibility resting upon them in the matter of securing properly qualified principals for their schools; and having been fortunate enough to secure such an one, have they been sufficiently imbued with the importance of reposing in that individual authority commensurate with her responsibilities, and the far-reaching effects of too frequently changing this important administrator? Is it not the responsibility of the hospital to realize the criticisms that are directed toward our schools today and to shoulder at least a part of the responsibility and seek a remedy? Has the time arrived when the nurse must begin to pay in another form than service for what she receives, in order that the dignity of her profession might be realized? Should we seriously consider the abolishment of the allowance plan and apply the funds so conserved to the educational advancement of the nurse? In the meantime, it is the obligation of hospitals conducting schools of nursing to provide a well organized, well balanced program for the education of the student and an adequate staff to provide the patients with the care they should receive.

Active consideration should be given to the question of nursing in mental diseases and steps should be taken to reach some definite procedure. There is probably no branch of nursing that is less understood and in which less definite lines of procedure have been worked out. We should not lose sight of our responsibilities concerning nursing care in communicable disease and in pediatric nursing. Have we in any degree of satisfaction strengthened the situation of the private duty nurse? Have we given the general duty nurse the consideration needed?

In the final analysis of all our problems do we not find the greatest number pivoting around the root problem, the economic one, and can we expect to see great changes in our schools until this has been in a more definite manner relieved? This, I believe to be one of the most important responsibilities of the hospital, through the public, though it is a responsibility that is too little recognized. Unless we can give to these problems serious consideration and deduce some measure of relief, the new curriculum so earnestly intended and carefully planned will be of little help.

Nursing has accomplished almost inconceivable results, it has even greater efforts stretching before it. Nursing will exist to the end of time. Within our hands and leaning upon our strength mankind enters and leaves the world. Ours is the care in the beginning and at the end and this was yesterday, is today, and tomorrow shall be, for we are told that the country whose inhabitants shall not say "I am sick" is afar off.

Success in all our undertakings is dependent on the sympathy and coöperative spirit of the individual members. Self-standardization of the individual with her constant and continued effort to carry out in a wholehearted way the policies of the organization are vitally necessary. But it calls, too, for vision—a social vision that shall be the logical product of a wholesome and well grounded philosophy of life. To give such a vision is the major objective of nursing education.

How Intelligent Should Our Nurses Be?

ANNA HYMAN AND RUTH DREYFOUS

THE confusion which arises when an attempt is made to arrive at an improved method of selection of student nurses is suggested by the results, and especially by the difficulty of interpreting the results, of a tentative experiment in administering intelligence tests to the students of a nurses' training school. These difficulties are inevitable when the problem is attacked as an isolated one, without reference to the related and perhaps primary issues pertaining to the standards and objectives of nursing education, especially with respect to the clarification of the most important qualifications for success in nursing. The results reported here are merely suggestive, but they are suggestive of problems to be attacked and of questions to be cleared up, rather than of any decision for or against the use of intelligence tests as an instrument of selection. It is from this point of view that they will be discussed.

How can we select the best from among the embarrassing number of applicants for entrance to our nurses training schools? Will intelligence tests help us? These are the questions which directors of training schools and hospitals everywhere are asking themselves. And the first of these questions, to which the second is clearly subordinate, is by no means a simple one. It depends for its practical solution upon the clearing up of a host of other questions pertaining to the definition of the actual and ideal standards of the nursing profession, and to the choosing of the most desirable methods of training for fulfilling the requirements of these standards. That the nursing profession is awake to these basic problems is demonstrated by the comprehensive study undertaken by the Committee for the Study of Nursing Education as reported by Josephine Goldmark in *Nursing and Nursing Education in the United States.*

This question of selection is one of practical appeal. Ultimately, an improved method of selection usually means a raising of the standards of a profession. More immediate gains are seen in the saving of time, labor, and expense to the training schools. For the students themselves, more definite standards of selection lessen the chances of failure and disappointment, as well as saving them also the time and energy which would otherwise be wasted in a vain attempt to accomplish that of which they are incapable. Moreover, there is always, from necessity, selection on some basis or other, since some of the applicants are chosen and others are rejected. This problem is therefore frequently chosen as the first point of attack. But actually, it is a difficult one to solve in any practical and helpful fashion until the other questions are cleared up to some extent. How can we tell, then, who are the best individuals for our purpose until we have defined our purpose clearly and analysed the qualifications which it implies?

More and more frequently intelligence tests are coming to be regarded as an important type of entrance examination, or method of selection from among a multitude of applicants. This is true in a few business and industrial concerns, in some branches of the civil service, and, most frequently, in schools and colleges of various types. But first it is necessary to decide (a) how closely success in the chosen field is related to the possession

of a high degree of the quality which is believed to be determined quantitatively by the test, and (b) to what extent is the possession of a high degree of this quality the most important factor in such success. At least we must attempt to determine the relation between success on the test with success in the undertaking on which he is about to embark. The highest correlations, so far, have been found between intelligence test scores and scholastic or academic success, but even here we do not escape from the conflicting factors of environmental circumstances, personality and character differences, and the influence of attitudes, interests, and desires. The question is always a complex one. In any attempt to estimate the value and desirability of using intelligence tests as a means of selecting the best individuals from among the applicants for entrance to a nurses' training school, these complexities remain and must be dealt with. Although investigations of the correlation of intelligence test scores with training school success have been reported by several authors, little conclusive evidence has been found.

It must be remembered, of course, that in training schools where the completion of the high school course is a requisite for entrance, a considerable degree of selection from the point of view of intelligence has already been effected. This was true of twenty-eight per cent of the nurses' training schools in the United States in 1918; and of the twenty-three first rank training schools intensively studied by the Committee for the Study of Nursing Education, thirteen required four years of high school for entrance.[1] The entrance requirements of the training school referred to here do include high school graduation. We are, therefore, considering here the relation of intelligence to success in nursing only with respect to the importance of varying degrees of ability above this predetermined minimum as a differential factor in such success.

The authors gave the Otis Group Intelligence Scale to the 128 student nurses and probationers enrolled in a nurses' training school. The Thurstone Cycle Onmibus Test was likewise given, a short time previously, to the probationers and to the senior nurses. One of the most interesting aspects of the results was the fact that the average score made by the probationers was approximately twenty points above that made by any of the other three classes. (See Table I.) This is especially interesting when we consider the fact that there has been no change in the entrance requirements during the past four years, and, moreover, that the teachers and directors of the training school declare that this class does not seem above the average in any way. The average scores made by the three upper classes correspond closely to Otis's norms for average unselected adults. The median score of the probationers, however, which shows a deviation of twenty points above this level, and approximates that of the normal-school group, seems thus to indicate that they are a more selected group from the standpoint of intelligence, in spite of the evidence given that no organized attempt was made to make a better selection, and that this seeming superiority has not, so far, been observed in their work. This contradiction raises many interesting questions, but before going into them let us take note of another aspect of the results of these tests that is perhaps of somewhat similar significance.

[1] *Nursing and Nursing Education in the United States*, J. Goldmark, 1923.

In an attempt to discover a tentative minimum score, that is, a score below which successful graduation from the training school was highly improbable, the probationers' scores on the Thurstone test were compared with those of the seniors. Although, as has already been stated, the average score for the probationers was considerably higher than that for the seniors, the lower limit of the senior scores did not extend as far down as did that of the probationers'. Nevertheless, if this lowest senior score had been taken as a criterion, only two probationers would have been excluded. But, as a matter of fact, later in the year, nine of the thirty-three probationers were dropped from the training school.

Of these nine, five had made the lowest scores in the class, ranking twenty-eighth to thirty-third. Two others ranked twenty-first and twenty-second, and the two remaining ones, thirteenth. This suggests that the lowest fifteen per cent of the class, at least, might have been eliminated at the time of application to the training school with no loss of good nursing material, and a considerable saving of time and expense. In terms of score, however, this procedure, had it been consistently followed in previous years, would have meant likewise the elimination of five seniors having Thurstone scores of thirty-eight or below, all of whom are about to become graduate nurses, and are considered satisfactory students by their supervisors. Here we find a further indication of the conflicting evidence presented by the results of these tests in the training school.

TABLE I—RESULTS OF THE THURSTONE AND OTIS INTELLIGENCE TESTS IN A NURSES' TRAINING SCHOOL, WITH NORMS OF COMPARABLE GROUPS

	Thurstone Scores				Otis Scores						
	Number Taking	Lowest Score	Median Score	Highest Score	Number Taking	Lowest		Median		Highest	
						Score	P.R.*	Score	P.R.	Score	P.R.
Seniors	22	33	52.5	95	19	82	5.3	130	50	179	95.1
Intermediates					52	80	4.6	133	54	176	94
Freshmen					32	80	4.6	132.5	53	191	98
Probationers	33	14	70	109	25	94	11.2	154	79	199	99
All classes in school					128	80	4.6	134.5	56	199	99

* P. R.—percentile ranking.

Median for Normal School Freshman (Thurstone [2])—73 (approximately).
Adult Norm (Otis [3])—130.
Normal School Median (Otis [3])—157.

This discrepancy shown between the achievement of the probationers and that of the graduating senior students on the intelligence test may be explained in several ways:

1. It may be a difference of attitude. The probationers may have thought that more depended on their standing on the tests than did the seniors who knew that they were graduating shortly and that the test results

[2] Thurstone, L. L., "A Cycle Omnibus Test for College Students," *Journal of Educational Research*, Vol. IV.

[3] *Manual of Directions*, Otis Group Intelligence Scale, third revision.

would not influence their ratings. The probationers, therefore, may have had more incentive to make a sincere effort to do well.

2. Another explanation may be that the probationers are closest, in point of time, to their academic school routine and so may have retained more facility in handling test material.

3. Again, there may be a true difference in mental ability between the two groups.

4. Finally, and this suggests itself as a crucial question, it is a possibility that the emphasis placed on discipline, routine, and obedience to orders in a nurses' training school may dull rather than foster the ability called for in these tests.

More widespread and continued testing of student nurses is the only way in which more light can be thrown on the question. It is the only way in which to discover whether the difference shown here is merely a chance difference between two groups of individuals, or whether it represents a general tendency. Furthermore, only by repeated testing of the same individuals during their progress through the training school can it be discovered whether or not this difference is significant of an actual decrease in the ability necessary for achievement on this test. If this were true, then an inquiry into the purposes, methods, and effects of the training courses for nurses would indeed become urgent. Is there a possibility that while the probationers are selected to some extent on the basis of intelligence, and are on the whole superior to the average unselected adult, in the course of learning to become nurses this ability is to a considerable degree trained out of them? Some of the qualities that perhaps tend to produce good scores on an intelligence test, and that the disciplinary régime of the training school may inhibit and tend to atrophy, are initiative, independence of thought, and alertness of mind. If this is true, is it done deliberately and purposely? And, if so, is it wise? These questions lead us back again to those raised in the beginning, which concerned the definition of standards and ideals, and the critical evaluation of methods of achieving them.

Do we really want nurses who are capable of thinking and acting on their own initiative, or do we want those whose outstanding characteristic is the capacity for subordination and the routine carrying out of orders? Are these two qualities irreconcilable? Which do we most emphasize under the present system of training? Should this system of training be modified by a change of emphasis?

The plan outlined by the Committee on *Nursing and Nursing Education in the United States* for standardizing the training of a group of subsidiary nurses to supplement the high trained ones offers one solution for this dilemma. There would then be two distinct groups, having separate functions, each group being more homogeneous, and so capable of being more definitely characterized than is possible under the present circumstances. This would probably simplify the task of analyzing and evaluating the various characteristics which constitute the most important factors of success in each type of nursing. It would, however, be far from eliminating this necessity.

We find, further, on considering the results of the test with the whole group of student nurses, that the scores made cover the whole range of ability. In terms of percentile ranking, they extend from the fifth to the ninety-fifth percentile (see Table I) or, in other words, individuals are included who are exceeded by only one per cent of the adult population, as well as individuals who are exceeded by ninety-five per cent of the adult population. If this is at all true of student nurses in general, it

certainly suggests that differences in intelligence, above the minimum standard already assumed as a requisite for graduation from high school, do not form an important factor in the qualifications for success in nursing, and that individuals considerably below the general adult norm in intelligence are not only capable of passing the nurses' training course creditably, and of becoming registered nurses, but that this is quite a usual occurrence. So that, while it may be assumed that intelligence undoubtedly is a factor in nursing qualifications, it is one whose importance is difficult to single out and measure. An attempt to determine with any degree of accuracy the most desirable level and type of intelligence to be required as a qualification for entrance into the nursing profession, will be faced with many difficulties and may prove to be of little value.

A possible hypothesis would be that differences in intelligence taken as an isolated factor, so long as the degree of intelligence remains within normal limits, do not have as much weight in determining future success in nursing as does the possession of other traits and characteristics: qualities pertaining to the physical make-up, the personality, and the acquired attitudes, interests, and desires of the individual. It is in this sense that intelligence-testing may prove to be a relatively unimportant and inefficient method of selection as compared with one in which an attempt would be made to define and measure whatever other qualities may prove to be more closely related to nursing ability. Young [4] has gathered some interesting data from this point of view, but he also stresses the need for evaluating the characteristics which he finds have some relation to success in nursing before any progress can be made toward their use as a means of selection. Whether or not intelligence as measured by these tests should be more important as a qualification for nursing, is another question, and has to do primarily with standards rather than with methods of selection. Again we find ourselves facing a complex problem for the solution of which we need not only more knowledge of actual present conditions, but a clearer definition of ultimate objectives and ideals.

These suggestions far from being the outgrowth of the results of an exhaustive study, are based on a very limited foundation, but the questions and problems that they point to, seem to be important ones, well worth considering, and for which it is urgent that answers be found if there is to be any progress in the direction of scientific selection of student nurses.

These questions might be restated as follows: What characteristics do the medical profession and the public require in a nurse? Are these requirements reasonable and progressive? What is the best method of training which will turn out nurses capable of meeting these requirements? And finally, what type of individual furnishes the best material as a foundation upon which this training is to build? These are the points upon which we must have more knowledge. The intelligence test, no more than the surgeon's knife, is a panacea, but is merely an instrument to be used for a specific purpose and with full knowledge of the conditions under which it is to be used, and of the benefits to be expected as the result of its use.

[4] Young, Herman H., "Intelligence Ratings and Success of Nurses in Training," *Journal of Applied Psychology*, Vol. VIII, No. 4.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR NURSING SERVICE, AMERICAN RED CROSS

Changes at American Red Cross Headquarters

SOMEONE said, when lamenting the more or less constant changing order of things, that nothing stays "put." It is natural and probably best for all of us that things do not stay "put" for advancement and progress cannot be made without change.

The resignation of Elizabeth G. Fox from the Red Cross Headquarter's official family, of which she has been a valued member since 1918, serving as Director of the Public Health Nursing Service since 1919, brings the first break in the service for more than ten years. Miss Fox leaves the Red Cross to become Executive Director of the Visiting Nurse Association of New Haven, Connecticut, and a member of the faculty of the Yale School of Nursing. While the Red Cross loses one of its ablest officials, it was but natural that Miss Fox, with her experience and natural gifts, would be interested in any plan that offers such a wide field of interesting activities. Assisting in developing a field of practice in public health nursing for student nurses suggests alluring possibilities, which in itself is vitally important and interesting. So, too, is the program of a large visiting nurse association, a field in which Miss Fox has had wide experience. Yet these alone would probably not have sufficed to draw her away from the Red Cross.

Through a coöperative arrangement with the Yale University School of Hygiene, Institute of Human Relations, and the Visiting Nurse Association, an opportunity will be afforded for study and research into certain aspects of public health nursing that have hitherto been untouched. The same qualities of mind, the same seriousness of purpose, which have characterized Miss Fox's work with the Red Cross, enabling her to build up an extensive and efficient public health nursing service, largely in rural communities, will stand her in good stead in this newer field of activity. During her régime with the Red Cross, its Public Health Nursing Service has grown from less than 100 services, under national direction, to its present size of over 600 services under Red Cross Chapter direction, employing 829 public health nurses. The adoption by the Red Cross of definite standards for work in the field of rural public health nursing has been an outstanding contribution not only in this field, but also in its reaction upon general public health nursing. The Red Cross standards in public health nursing have won universal respect and approval from state and local health departments and visiting nurse associations, as well as from the professions of nursing and medicine, individually and collectively. Within local, national, and international nursing organizations, Miss Fox has been highly regarded. Through her statesmanlike manner of dealing with important questions of organization, function, finances, and specialized education, she has rendered conspicuous service in many directions, but particularly in the field of preventive

nursing. She leaves many warm friends in the Red Cross, both at National Headquarters and throughout the organization, whose good wishes go with her to her new field of service.

Our New Office Building—Its Relation to the Delano Memorial

EVER since the World War the majority of Red Cross Services and clerical workers, as well as the records of over 50,000 Red Cross nurses and chapter correspondence files, have been housed in a temporary office building in the rear of the beautiful Memorial to the Women of the Civil War which is used as National Headquarters by the American Red Cross. Gradually this office building has deteriorated and grown very shabby. Permission to construct a new office building on the same lot, recently granted by Congress, has brought a feeling of relief, as well as gratitude, to the entire staff. In recognition of the semi-official character of the Red Cross, an appropriation of $350,000 accompanied the permit. The Red Cross has appropriated an equal amount.

Red Cross nurses, as well as others, will be interested in this plan, for the erection of a new building on the west side of the lot and the removal of the old office building release a large space, opening to the south and facing the buildings occupied by the Daughters of the American Revolution, for the erection of the Delano Memorial. The grounds will be landscaped to harmonize with the Memorial, the exact character of which, while not yet definitely settled, will be carefully considered by the Memorial Committee in coöperation with the Fine Arts Committee and the architect. When completed, the large square will be adorned on the east by the Memorial to the Women of the Civil War and on the north by that to the Women of the World War (used by the District of Columbia Chapter of the Red Cross as its headquarters), and with the new office building on the west, which will conform architecturally with the two Memorial buildings, will make a suitable as well as harmonious and artistic background for a Memorial to Jane A. Delano and the 296 Red Cross nurses who died in line of duty during the World War.

Clara Barton Flag Given to Red Cross Museum

THE first American Red Cross flag believed ever to have been made, the handiwork of Clara Barton, founder of the society, and of Mrs. Julia Babcock Hibbard, formerly of Washington, was presented recently to John Barton Payne, Chairman, by Mrs. Lowell Fletcher Hobart, President General of the Daughters of the American Revolution.

The flag was entrusted to the Daughters of the American Revolution for its museum by Mrs. A. Emerson Babcock of Rochester, New York, niece of Mrs. Hibbard. The D. A. R. Board decided that the flag properly belonged to the Red Cross Museum to be placed among historic relics of the Red Cross. The flag is fifty-five by ninety-five inches, and in fine condition.

Items of Interest

JANE C. SMITH, a member of the Red Cross Nursing Service, returning her questionnaire for this year, sends some interesting "bits" about her work as Missionary in Cairo, Egypt. In a postscript she writes:

> If you know of anyone visiting Egypt this year, or later, won't you please let me know? I should love to meet them and might be able to help them.

Miss Smith can be reached at 9 Sharia Massond, Abbassia. We have not heard of any nurses or others who are visiting Egypt, but, from experience in other countries, we have good reason to remember what a wonderful help it has been to receive assistance and advice of some one who has lived in the country, while the visitor from home brings to her a new interest and many times helps to allay the inevitable pangs of homesickness. We gladly pass on Miss Smith's invitation to nurses who may be planning a trip to Egypt.

* * *

From letters that are reaching us at National Headquarters we draw the conclusion that a good many of the state nurses' associations have designated their official delegates to the Annual Convention of the American Red Cross which begins May 5th, and continues through the 8th. We are looking forward with a great deal of pleasure to receiving these delegates, as well as visitors. The program which has been completed sounds very promising, as well as interesting. The President of the United States, who is also the President of the American Red Cross, will open the convention. Luncheons, dinners, drives, etc., are being arranged for the entertainment of the guests. Those associations that have not sent the names of their official nurse delegates are urged to do so as promptly as possible.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Anna Taylor; Ruth B. Taylor; Cornelia Merritt Thomas; Mrs. R. F. Thomas, *née* Florence Belle Taylor; Mrs. Earle J. Thomas, *née* Kathryn MacGregor; Mrs. Marie Naomi Thomas, *née* Shriver; Laura Thompson; Mrs. O. S. Thompson, *née* Margaret Ellen Hollar; Kathryn Tiernan; Mrs. C. W. Tittle, *née* Muriel Celeste Knupp; Mrs. William L. Trennery, *née* Elizabeth Murray; Mrs. J. F. Tucker, *née* Edith Catherine Anderson; Mrs. Edward Tucker, *née* Florence Cornes; Catherine Mary Tully; Gretchen Gladys Utter; Mrs. John A. Van Hoosen, *née* Florence Ruth Baker; Ethel Mae Verble; Mrs. Harry Wadsworth, *née* Myrtle Hafer; Mrs. Willis Wahl, *née* Olive B. Dressel; Sara Alice Wanlass; Mrs. E. E. Walborn, *née* Olive Elizabeth Mudge; Eunice B. Walker; Winnifred K. Warren; Pearl Laura Watson; Mrs. Harrly L. Weaver, *née* Sara Agnes Sutton; Elsie L. Weeks; Mrs. Hazel E. Wertheimer, *née* Sanor; Mrs. Clyde Whaley, *née* Kathryn Helena Brothers; Mrs. G. W. Whitchurch, *née* Grace McClelland; Hazel M. Whitemore; Vera Elizabeth Whitlock; Mrs. Flora Belle Wigton; Mrs. Paul Wilcox, formerly Mrs. Lena J. Green; Mrs. George M. Wilcox, *née* Ruth M. Tavender; Mrs. Ada Griffith Williames; Pearl Williams; Laura May Wilson; Mary Jane Wolfe; and Mrs. Augusta Condon.

The Child's Bill of Rights

THE ideal to which we should strive is that there shall be no child in America:

That has not been born under proper conditions.
That does not live in hygienic surroundings.
That ever suffers from undernourishment.
That does not have prompt and efficient medical attention and inspection.
That does not receive primary instruction in the elements of hygiene and good health.
That has not the complete birthright of a sound mind in a sound body.
That has not the encouragement to express in fullest measure the spirit within which is the final endowment of every human being. — *Herbert Hoover.*

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 250 words; anonymous letters are not considered

When Doctors Disagree—?

THERE is plenty of evidence that the treponema may be secluded in the mother's milk. Inoculation experiments with milk have been positive on numerous occasions in experimental animals. Before the days of the Wassermann reaction, wet nurses were, of course, a common source of infantile infection although this involves direct contact of the baby with the breast. So far as I know, there is no evidence that women who supply milk stations may give rise to infection by indirect contact, especially when the milk is pasteurized. Were I attempting to feed an infant of my own, however, I should certainly be careful to see that the milk came from a Wassermann negative woman.

M. D.

In the February issue of the *Journal* the question was asked, "Is there any danger that the milk of a syphilitic woman may infect a non-syphilitic child, so that the disease may be transmitted by wet nurses or by the women who supply milk stations?" This question was answered in the negative by an authority in the subject; however, the following from Rosenau's *Preventive Medicine and Hygiene* (Appleton, 1921, page 62) may be of interest to *Journal* readers: "The milk of a syphilitic woman must be regarded as infectious, since it is well known that a syphilitic wet nurse without lesions will almost surely infect a healthy child; the spirochaetes, therefore, appear to be transmitted in the milk."

Who Can Offer a Solution?

IT seems to me it would be a wonderful thing for the *American Journal of Nursing* to take up a discussion of what is to become of the older nurses who have all their faculties, such as hearing, sight, a clear brain, and a good pair of legs to walk on. Although we were the pioneers in the nursing field, there does not seem to be any place for us, that is, if sixty is really old. Still having all my faculties, I applied to a certain registry for hourly nursing. I was informed by the Registrar, in the most tactless way, "You are too old; we do not keep any more of the older nurses on the registry." This I found only too true. Meeting a fellow-nurse, she informed me she had been turned down for the same reason. That nurse was forty-five.

When is a nurse too old to practice? They simply cannot all have sufficient money saved, if they have had to depend on their earnings alone, for when I began nursing the pay was small. There is something wrong when a registry cannot take care of all ages on their files. And the nursing field is wide enough to have work for all if properly organized. Can anyone suggest work for nurses from fifty to seventy years of age?

New York. A. C.

Icelandic Nurses in Foreign Countries

ICELANDIC nurses desiring positions in the new State Hospital of Iceland, to be opened in Reykjavik in the autumn of 1930, are requested to send their applications to the Icelandic Nurses' Association, from which further particulars may be obtained.

(MRS.) SIGRIDUR THORVALDSSON,
President of the Icelandic Nurses' Association.
14, Tjarnargata, Reykjavik, Iceland.

The Millennial Anniversary of the Foundation of the Icelandic Parliament

NURSES who may be visiting Iceland on the occasion of the celebration of the Thousandth Anniversary of the foundation of the Parliament of Iceland, June 26–30, will be welcomed by the Icelandic Nurses' Association, which will be glad to assist them in every way to make their stay there as interesting as possible. Please write to Mrs. Sigridur Thorvaldsson, President of the Icelandic Nurses' Association, 14, Tjarnargata, Reykjavik, Iceland.

In commemoration of the granting, on June 19, 1915, of women's suffrage in Iceland, the Icelandic women founded a fund for the building of a state hospital which is to provide complete education for the medical profession in Iceland as well as for nurses and midwives. The fund has been generously subscribed to

and has also been subsidized by the Government, and the hospital will be ready for use this year of the millennial festivities. Hitherto the Icelandic nurses have taken part of their training in the various hospitals in Iceland, and the rest has been taken in hospitals in Denmark and Norway, as Icelandic hospitals have not offered sufficient practical experience. The Icelandic Nurses' Association has been advising on all the arrangements with regard to the nursing service of the new State Hospital, and have had some difficulty in getting a three years' course accepted, several of the more prominent citizens feeling that Iceland could not afford to provide more than two years' training for its nurses.

The early history of the Parliament of Iceland (Althinget) is known from the famous collection of Icelandic poems, the "Eddas."

A Student Club

MISS LAW, Missouri State Inspector of Training Schools, has suggested that I write you of our Nightingale Club, which was organized in March, 1925, with twenty-two student nurses, and now has fifty-two and several applications for membership. Our name is for Florence Nightingale, and we use Robert's parliamentary rules. We meet the first and third Monday nights of each month in the nurses' living room. The object is educational and social. Active membership is composed of the student body, though graduates may become honorary members. A student nurse will always be considered a member, though she passes from active to honorary with her graduation from the school. The club has furnished a patient's room at a cost of $260, and their living room at a cost of $115.25. The club has given a vase shower to the hospital, and several other small donations. A reserve is always held in the bank for an emergency. We give at least one picnic during the summer, an annual costume Hallowe'en party, a Christmas program, and a banquet for the graduating class in May of each year. We remember doctors and relatives of nurses with flowers in time of illness or affliction. With dues only ten cents per month, for each member, you will wonder how we do all this, but we do, although we wonder at times, too, how we will accomplish all we undertake.

MRS. HARRY E. MOODY,
Missouri. *Club Sponsor.*

Growth at St. Luke's, Davenport, Iowa[1]

WE have accomplished a few minor things which I am sure will please you. First, we have discontinued our student allowance. We give, or provide, all uniforms, including school cape and four pairs of shoes each year; all textbooks are provided for each class, in addition to reference books. Three copies of the *American Journal of Nursing* are placed in the library each month. Second, we were able to arrange an affiliation for pediatrics. Third, I have been able to add another graduate supervisor to our staff.

Our first floor is medical; second, surgical; third, obstetrical; fourth, eye, ear, nose and throat; and fifth fracture. Every department is supervised by a graduate. French Hall, the nurses' residence, grows prettier day by day, the students enjoy their music room and every space is used.

I. CRAIG-ANDERSON,
Superintendent.

Information Desired

INFORMATION is desired concerning the names and, if possible, present addresses of nurses, both graduate and practical, who served at the Washington Hospital for Foundlings during the months of February and March, 1896. This information is desired solely in order to establish the identity of a most reputable young man.

MOHUN AND ELLIOTT,
Transportation Building, Washington, D. C.

Englewood Nurses, Please Note

WILL all graduates of Englewood Hospital, Chicago, Ill., please communicate with the Superintendent of Nurses as to their present location and occupation?

M. R. HINEMAN.

Too Many Nurses

NURSES who are contemplating coming to Fort Worth, Texas, we are sure will be glad to know, before they spend their time and money, that there is not work for nurses who are here, and has not been for many months.

MAUD MARTIN,
Corresponding Secretary, District 3. Texas.

[1] Excerpts from a personal letter, published by permission of the writer.

AT the last meeting of District 2, Tucson, it was decided unanimously by the nurses doing private duty that steps be taken to notify visiting nurses of the serious problem of unemployment for nurses here. This information may save them considerable money.

L. EVELYN SCHMIDT,
Arizona. *Secretary.*

Oregon Law Compulsory

OREGON nurses wish to call attention to clauses in the laws governing nursing in that state which read:

"It shall be unlawful hereafter for any person to practice or attempt to practice nursing in this state as a trained, graduate or registered nurse without a certificate from the board. Any person who has received his or her certificate according to the provisions of this act shall be known as a registered nurse and shall be entitled to append the letters 'R.N.' to the name of such person. No other person shall assume or use such title or the abbreviation 'R.N.' or any such words, letters or figures to indicate that such person is a trained graduate or registered nurse, or otherwise represent himself or herself as licensed, authorized or entitled to practice nursing in the state of Oregon as a trained, graduate or registered nurse.

"Every person holding a certificate from the board of examination and registration of graduate nurses shall renew annually his or her registration with said board and every registered nurse who desires to retain his or her registration in the state of Oregon shall, annually, after the expiration of the first year's registration and on or before the first day of July of each year succeeding, file an application for renewal with the board and pay a fee of one dollar ($1), for which a renewal certificate shall be issued by the board. A penalty of one dollar ($1) shall be added to the renewal fee of every registered nurse who fails to comply with this provision within sixty (60) days from and after the first day of July of each year, and if said renewal fee is not paid with all penalties due thereon before the first day of January following, thereafter the certificates of all registered nurses failing to comply with the provisions heretofore named shall be canceled, and such certificates may only be renewed thereafter upon written application to the board and the payment of a fee of ten dollars ($10)

A Correction

IN the March *Journal*, page 362, in a report of the annual meeting of the Central District of Maine, it was stated that the meeting was presided over by Nora Rowell. Margaret L. Pearson presided; Miss Rowell is secretary. Miss Pearson was elected president at that meeting.

Journals *Wanted*

RUTH E. MASON, Chief Instructor, Training School for Nurses, University Hospital, Parnassus and Third Avenues, San Francisco, wishes to secure copies of the *Journal* for October, 1900, through December, 1901. She will pay for the magazines and for the cost of shipment.

Hilda M. Torrop, Superintendent Winchester Hospital, Winchester, Mass., wishes to purchase a complete set of the *Journal*, from 1900 on.

M. Barbara Anderson, Instructor, Butler Hospital, Providence, R. I., wishes to obtain copies of the *Journal* before 1913.

Journals *Wanted and on Hand*

BERTHA I. BAUMGARTNER, Superintendent, School of Nursing, Halstead, Kans., will pay 25 cents a copy for the following: 1912, June; 1913, September; 1914, January; 1915, March, June, September; 1919, January; 1920, September. She has the following *Journals* on hand: 1916, June; 1917, July; 1918, May, July, August; 1919, March, April, July, August, September; 1921, all except April, November and December.

Journals *on Hand*

MRS. CHARLOTTE HEILMAN, Care American Red Cross, 598 Madison Avenue, New York, has a complete set of the *Journal* for 1929 which she will send to anyone who will pay the postage.

Margaret Clarke, Waterville, N. C., has copies of the *Journal* for September, October and December, 1928, and January through May and September, 1929, which she will send to anyone sending postage.

Miss Nelle Smallwood, 1217 E. Preston Street, Baltimore, Md., has copies of the *Journal* which she will give away for the postage: 1925, except January, February, April; 1926, except June; 1927, except February and March; 1928, except August; 1929, complete.

Maternity Center of Brooklyn, 42 Livingston Street, Brooklyn, N. Y., has copies of the *Journal* for 1928, complete, and odd numbers of 1929 to give away.

Student Nurses' Page

Avertin[1]

GARNETTE NESTER

Church Home and Infirmary School for Nurses, Baltimore, Md.

AVERTIN, advocated by Eichholtz, is a crystalline salt which is soluble at a temperature of 98.6 degrees F. up to 3 per cent, and is easily absorbed by the mucous membrane. From a practical standpoint one must know that this substance, above 122 degrees F. and also under the influence of light or air, easily disintegrates and that some of the disintegration products are severe irritant poisons. As a result of this one must adhere strictly to the directions for preparation of solutions for rectal injections. At no time should the temperature be above 105 degrees F. A watery solution, freshly prepared, which is easily tested may be used as a standard. Avertin in lower dosage is hypnotic and in higher dosage it is narcotic. It is eliminated from the body by the kidneys.

Avertin has found exclusive application as a rectal anesthetic. It is a surgical narcotic, introduced to eliminate the psychic element and produce a so called "basal anesthesia." It is not intended that avertin should be used alone to produce complete anesthesia.

The preoperative preparation is the customary cleansing enema the evening before operation. It has been recommended that rectal irrigation be avoided immediately before the administration of avertin solution as the fluid which remains in the bowel may retard absorption. About one-half hour before the anesthetic, a hypodermic injection of morphia 1/6 to 1/4 grains is generally ordered.

The necessary amount of avertin is calculated according to the weight of the patient, 80 to 100 mg. per kilogram body weight. It is dissolved in a sufficient quantity of distilled water to make a 3 per cent solution.

In preparing the avertin solution it is necessary to follow the directions implicitly so as to avoid complications. The temperature is a most important factor. If the solution is allowed to cool, crystallization of the avertin takes place and renders it unfit for use. The following test should be made immediately before administration when the 3 per cent avertin solution is ready for use. Place 3 cc. of this solution in a test tube and add two drops of Congo-red solution 1–1000. The resulting color of this mixture should be clear orange red, change of color to blue shows the presence of free hydrobromic acid, and therefore indicates a decomposed solution.

[1] Presented in connection with a demonstration at the annual meeting of the Maryland State League of Nursing Education, Baltimore.

The mode of administration which is advised is a slow rectal injection. Usually the patient becomes drowsy and falls to sleep within from two or three to fifteen minutes. The average duration of the anesthesia with 100 mg. avertin per kilo body weight, possibly supplemented with a small amount of ether, is about one and one-half to two hours.

Immediately after regaining consciousness most patients fall into an agreeable sleep during which post-operative pain is not experienced. Vomiting, so common and distressing after ether, is practically absent in avertin basal anesthesia.

The respiratory center is practically uninfluenced by a dose of avertin sufficient to induce anesthesia. The blood pressure is affected far more frequently. Dr. S. Griffith Davis has found that after a dose of avertin a case of hypertension may drop as much as 100 points while a normal blood pressure is rarely changed.

Avertin has been used in practically all types of operations. It has been found especially useful in cases of convulsions caused by brain tumor, eclampsia and tetanus. The observations in the surgery of children are much like those witnessed in adults. The only difference is that children in general do not respond as well to the proportional adult dose.

Diseases of the liver must be regarded as contraindications, also renal disease, acidosis, extreme cachexia, and advanced pulmonary tuberculosis.

One of the effects noticed in early clinical tests was irritation and injury of the intestine. It was shown, however, that this was not due to the avertin itself but to its by-product, the extremely irritating dibromacetaldehyde, which resulted when the solution was excessively heated. When the directions for the preparation of the solution were strictly followed intestinal irritation did not occur. Death occurring from acute avertin poisoning is due to marked lowering of the blood pressure until the heart ceases to function.

References

"Laboratory Data" from the Research Department of the Winthrop Chemical Company.

Researches in Anesthesia and Analgesia—the official organ of the International Anesthesia Research Society. Volume 8, Number 1.

"Recent Progress in Anesthetics in Germany," by Hans Killian, M.D., Freiburg, Germany.

"Inhalation or Injection Narcosis?" by C. Helmut Schmidt, M.D., Hamburg, Germany.

These papers were read in Minneapolis at the Seventh Annual Convention of Anesthetists of the United States and Canada in joint meeting with the International Anesthesia Research Societies.

Training of Nurses

THE paramount necessity is to separate the training school organization from that of the hospital. At present there is neither separate financial provision for the training school nor separate administrative authority. Consequently the interests of the training school are not properly regarded, and these become subservient to the needs of the hospital. This is in marked contrast to the medical schools, which have their own finance and organization. The time has come when the probationer should be looked upon as a student and not as a source of cheap labor for the hospital authorities. The greater part of such work as cleaning the wards, etc., should be given over to maids and orderlies (but in this work nurses should be given adequate training), and the permanent nursing staff should be greatly increased. In this way the probationer's time will be entirely given over to the study and practice of her profession.—From "The Labour Party and the Nursing Profession," report of a conference held in London, in January, 1927.

Questions

Will you please state how the states reciprocate? What states require State Board before registering an outsider? Do California, Colorado, and New York reciprocate with Kansas?

In each of our forty-eight states we have what is called a Registration Law, or Nurse Practice Act. States have many things in common, but reciprocity between states does not exist in every instance.

There are four outstanding requirements which may determine the ability of a nurse to register in a given state. They are:

1. Registration of a given school in a given state.

   The state of New York does not reciprocate with any state, but requires that the school of nursing, no matter in what state it may be located, must be registered by the Regents of the University of the state of New York before the graduates of that school are eligible for registration in the state of New York.

2. Meeting minimum state requirements.

   Some of the states have based their decision to establish reciprocity with a second state, upon the ability of the second state to meet the minimum requirements for accredited schools of nursing and registration of nurses, as outlined in the laws and the board rulings of the first state.

3. Meeting individual requirements.

   In some instances, states have based their decision to grant reciprocity with a second state upon the individual qualifications of the nurse seeking registration by reciprocity from that state.

4. Meeting special requirements, such as being able to present an honorable discharge from the Army or Navy.

Therefore, if you wish to learn whether you are eligible for registration in a given state, the proper procedure for you to follow is to write to the secretary of the state board of nurse examiners in the state in which you desire to register and inquire whether you are eligible for registration in that particular state, also whether you are eligible for registration by reciprocity. You will find the names and addresses of the secretaries of state boards of nurse examiners listed in each number of the *American Journal of Nursing*, in the section marked "Official Directory."

When writing, it is advisable to give the secretary the following information:

Your name and address.
Name and address of the school of nursing from which you are graduated.
Length of course in the school from which you graduated.
Date of graduation.
States in which you are registered.
Date and number of registration in each state.
How you are registered in each state; that is, by waiver, reciprocity, examination, or special provision, such as holding honorary discharge from the Army or Navy.

All of these factors may have a direct bearing upon your ability to register in the second state.

ALMA H. SCOTT,
Assistant Director, A. N. A.

Please give diet for typhoid which would be safe to give a patient suffering from diabetes.

A typhoid diet should be a high caloric one, and if the diabetic patient has a high blood sugar insulin would be ordered to take care of the carbohydrate.

The diet should be composed of milk, cream, cereals, cheese, chicken, and chopped meat with any of the 5 per cent vegetables.

Please give diet for a patient suffering from colitis with ulcers, in addition to a bad case of diabetes.

A colitis diet should contain no roughage; all vegetables should be pureed, and milk, custards, junket, and soft eggs may be given. If the blood sugar is high, insulin would undoubtedly be ordered to take care of the carbohydrate.

BERTHA M. WOOD.

Abstracts

Sodium Amytal: A. R. Robbins, M.D., and others. From the Medical Research Department of the Indianapolis City Hospital and the Department of Obstetrics of the Indiana University Medical School: The Use of Sodium Iso-amylethyl Barbiturate (Sodium Amytal) in Obstetrics. (*The American Journal of Obstetrics and Gynecology*, September, 1929.)

Sodium amytal has been used in more than 100 cases in our series. It has been administered in all stages of labor, orally, intramuscularly, intravenously, and rectally. It has been our desire to abolish the pain of labor, or at least the remembrance of it.

We found very little slowing, if any, in the progress of labor. We had an apparent temporary delay in four cases, the longest being one hour. Uterine powers were impaired little, if any; however, voluntary powers in the first stage of labor were markedly diminished and the patient, at times, was unresponsive to uterine contraction. Voluntary powers in the second stage may be affected, but not to any marked degree and not over thirty minutes.

Fetal heart rates showed an average change of ten, the greatest variation being thirty; and the least, five per minute. The size of the dose bore no relation to the degree of variation. The fetal heart rate varied widely during labor over very short periods of time so that these variations were all within normal limits.

In most of the cases reported, the intravenous method of administering the drug was used. By this method we were better able to control the dosage and to make accurate observations. Also, the effects of the drug were rapidly obtained.

As a preliminary report, we feel justified in drawing the following conclusions: (1) The most serious objection to the use of sodium amytal as an analgesic was the difficulty in controlling the patients who became very restless. (2) This drug has the advantage of being rapid in its action and of having a wide range of safe dosage. (3) There has been no evidence of harm to the mother. (4) Labor is probably not delayed. (5) Labor may be rendered practically painless. (6) Obstetric operative procedures are much more easily carried out under ordinary anesthesia when the operation is preceded by sodinm amytal. (7) Danger to the baby has not been proved. (8) Prompt and complete control of eclamptic convulsions is possible. (9) As a general anesthetic agent for cesarian sections and other obstetric operations and especially for patients having tuberculosis or toxemia of pregnancy, sodium amytal bids fair to supplant the inhalation anesthetics.

Sodium Amytal: Mabel B. Kast, M.D. Sodium Amytal as an Anesthetic. (The *Indianapolis Medical Journal*, April, 1929.)

Interest in a new anesthetic, although we have so many at the present time that there would hardly seem to be a place for one more, is still strong enough to bring out the fact that we have not, as yet, one ideal anesthetic for every surgical procedure. Dr. Kast reports a series comprising thirty-five different kinds of operative work, the greater proportion being thyroidectomy, and next to that, mastoid operation. In the majority of the cases the sodium amytal was not relied upon for the entire anesthesia, morphin, local anesthesia, nitrous oxide and ether being combined with it, to produce full operative anesthesia. After a description of the method, which is simply, a very careful intravenous injection of sodium amytal, she takes up the disadvantages and the advantages of this anesthetic. The advantages seem to be quite identical with those of scopolamin-morphin, but the disadvantages of sodium amytal, which she notes, are quite removed from scopolamin-morphin anesthesia, and in this way make a difference in favor of the latter.

Conclusions

Disadvantages:

1. Difficulty in getting into veins.
2. Sloughs at site of injection, injury to nerves during administration.
3. Difficult to combat depression with faulty administration.
4. Prolonged sleep requiring constant nurse vigilance.
5. Blood pressure drops.

Advantages:

1. Patient may go to sleep in bed, in own room, easily and naturally.
2. Awakens in bed in own room.
3. No nausea or emesis, even when ether has been used.
4. Gas anesthesia facilitated, making it possible to use gas more generally than before.
5. Many cases require no anesthetic agent in addition for certain operations.
6. Reduces postoperative requirement for morphia.
7. Efficient adjuvant to general anesthetic agents.

Discussion of Basis for Diagnosis of Gout and "Presumptive" Gout: P. S. Hench, M.D. *Proceedings of the Staff Meetings of the Mayo Clinic*, December 11, 1929.

We know so little about gout that even definitions are difficult to make. It is generally defined as a constitutional disease affecting joints and associated with alterations in purine metabolism. Some textbooks define it as "a disease of metabolism associated with an increase in blood uric acid . . ." thereby implying that unless there is an increase of blood uric acid the diagnosis cannot be made. Since the work of Garrod and of Folin, it is the custom to accept statistics on gout only if the patients in cases so diagnosed have (1) increased blood uric acid, (2) tophi, or (3) so-called characteristic punched-out areas in the roentgenogram, and only if they give a history of attacks of acute arthritis, preferably in the great toes. Since the War and the advent of prohibition, many feel that gout is becoming rare in America. We feel that the rarity, at least in diagnosis, is partly due to national prohibition, and partly due to lack of the proper basis of suspicion. The disease is less often expected or suspected.

Blood Transfusion and Syphilis: Henri Dufour. (*Bull. et mém. Soc. méd. d. hôp.* Paris, 1929, XLV, 3rd ser., 511.)

A young woman who developed marked anemia during a second pregnancy was given a blood transfusion in July, 1926. Neither her husband nor she had syphilis, and the blood Wassermann reaction had been negative before transfusion. Two months and a half later, the patient developed a rash. Soon the Wassermann reaction became positive. Neosalvarsan and bismuth rendered the reaction negative and the rash disappeared.

Marshall reports a case of blood transfusion in an elderly woman who developed typical syphilis and a positive Wassermann reaction within four weeks. The transfusion constituted an emergency, and later it was found that the donor was undoubtedly syphilitic and had a positive Wassermann reaction.

Serum Disease and Serum Accidents: G. M. MacKenzie, M.D., and Franklin M. Hanger, M.D. (*Journal of the American Medical Association*, January 25, 1930.)

. . . In this paper the term serum disease or serum sickness refers to the clinical and immunologic phenomena which occur in an indivudal who, prior to the administration of the serum, is not hypersensitive to the foreign serum administered. It is the usual, or perhaps one might say the normal, response of man to the parenteral introduction of foreign serum. Serum accidents, on the other hand, are the sudden, often alarming or even fatal, reactions of individuals who are hypersensitive to the serum employed. . . . Since it is an almost universal custom to use the horse for the production of antiserums, the problem is confined to a consideration of the differences in response to horse serum of the hypersensitive and the non-sensitive individuals. The specific antitoxic, opsonic, lytic or agglutinating properties of the serum do not enter into the problem of serum disease and serum accidents. . . . It should be clearly understood that . . . concentrated serums still contain horse serum proteins capable of causing all types of serum reactions. . . .

Numerous factors doubtless influence the incidence of serum disease to a slight extent. Differences in individual susceptibility are apparent. . . . North American Indians and negroes appear to have a relatively low susceptibility compared to that of the white race . . . the serum from some horses causes more serum disease or more severe symptoms than the serum of other horses. The one factor, however, which determines the incidence of serum disease more than anything else is the quantity administered. . . . When such small amounts as are commonly used to immunize with diphtheria antitoxin are employed, a large percentage of patients have no obvious manifestations of serum disease; but when, as in the use of antipneumococcus type I serum, quantities of from 100 cc. to 1,000 cc. or more are injected, a very small percentage of patients escape at least some distinct evidence of serum disease. . . . Individuals treated with serum for the first time usually have an incubation period of from six to twelve days before the onset of the symptoms of serum disease . . . It is well established that a serum injection weeks or months or years before the second injection is very apt to cause a shortening of the incubation period.

. . . . There is a syndrome which should be readily recognized: an interval, following the serum injection, of from six to twelve days without symptoms and then urticaria, erythema, enlargement of lymph nodes, arthritis, fever, edema, and, in some cases, enlargement of the spleen. . . .

. . . When the serum accident is mild, the only symptoms may be a few urticarial wheals, itching or prickling sensations, and a feeling of uneasiness or apprehension. In more alarming cases urticaria and erythema are generalized and severe; there is cyanosis, dyspnoea, edema of the face, tongue and throat, coughing, frothy expectoration, and sometimes collapse. In rare cases death has occurred. The symptoms of serum accidents may come on explosively even before the injecting needle is withdrawn. . . . There are two groups of individuals susceptible to such accidents. The first group consists of those who have an immediate reaction when serum is administered to them for the first time. Some of these people are the well known "horse asthmatics." . . . Many of them belong to families in which allergic diseases are frequent. . . . It is this group which has provided most but not all of the deaths from serum accidents. . . .

The second group consists of those individuals whose sensitiveness to horse serum has been produced by a previous injection of serum. With the constantly increasing use of immunizing and therapeutic doses of serum, this phase of the problem has become of great practical importance. . . . Probably most physicians who have treated infectious diseases have seen patients who, on receiving a second serum injection after an interval of two weeks or more, promptly developed itching, urticaria or erythema, cyanosis, perhaps swelling of the lips or face, and dyspnea. . . .

The ratio of severe and fatal reactions to the number of serum administrations is obviously very small. . . . From the records of reported cases and from numerous personal communications, we are inclined to believe that several points in connection with serum accidents are well established though not generally known: (1) Compared to the spontaneously sensitive "horse asthmatic" group, the individuals sensitized by a previous serum administration are in general much less sensitive to horse serum. (2) Fatal accidents have occurred in both groups. (3) Only a very small percentage of those artificially sensitized reach a dangerous degree of sensitization. (4) In both groups the variation in the intensity of the sensitization covers a very wide range. (5) Minute quantities of horse serum, parenterally introduced, suffice . . . to increase the reactivity of the individual to the horse serum administered. (6) Serum accidents due to horse serum are avoidable. . . .

The prevention of alarming and tragic occurrences from the use of serum may properly be considered under two headings: (1) the identification of those who are hypersensitive to horse serum and an approximate estimate of the degree of sensitization; (2) the measures by which desensitization or an increase in tolerance may be attained.

A history of asthma and particularly of symptoms from contact with horses should put one on guard. . . .

. . . . Even in the absence of previous symptoms of allergy and previous serum administration, the safest procedure is not to inject serum without first making a skin test. The technic . . . is simple. After the skin of the forearm has been cleansed with alcohol . . . not more than 0.05 cc. of a 1:10 dilution of the serum is injected into the skin. Control tests with salt solution or normal human serum should be done at the same time. If at the end of from ten to twenty minutes the injection wheal has enlarged and a zone of erythema has formed around it, the reaction should be regarded as positive, provided the control tests have not behaved in a similar way. . . . Serious accidents have been reported when the cutaneous wheal was absent, nevertheless the test should not be omitted, as it is the best index of sensitivity.

Suppose that one is confronted with a genuine "horse asthmatic" ill with meningococcus meningitis, or a patient previously treated with antipneumococcus serum who shows a strong skin reaction to horse serum in the midst of a severe tetanus or diphtheria. The individual is clearly sensitized to horse serum and at the same time his life depends on the administration of horse serum in large amounts. . . . Unfortunately, desensitization in man cannot be attained with the rapidity, certainty, or completeness characterizing the phenomenon of desensitization of laboratory animals. Nevertheless, the methods holding out the best hope have been derived from methods successful with animals . . . . There are probably a few individuals with extreme sensitization to horse serum who cannot be desensitized by any method, at least not to a point at which they will tolerate serum in therapeutically necessary amounts. One may occasionally find too that after a few desensitizing doses the patient gives a prompt reaction with disturbing symptoms. . . . The majority of patients however, after persistent efforts, will become, for practical purposes, desensitized.

News

Note.—News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication

The American Nurses' Association

Membership

Congratulations, state associations and districts and all other parts of the nurses' official organization. Membership in the American Nurses' Association for 1930 has reached the total of 84,138. The net increase in membership is 5,162 for the year.

Bulletin

The monthly *Bulletin*, issued from A. N. A. Headquarters, was begun a year ago in its present form. It proved so successful a means of reaching the nurses of the country through their state bulletins and similar agencies, that the Board of Directors allocated funds this year for a considerable increase in its distribution.

Beginning with the March issue, therefore, the mailing list was enlarged to include national officers and state presidents, accredited schools of nursing, official registries, state nursing publications, national health publications, health libraries, and a selected list of newspapers, a total of 2,194.

This is one of the means being taken constantly by Headquarters to be of practical service to the constituency. Eighty-four thousand members cannot be reached individually with the limited budget upon which Headquarters and the work of the national office are organized. But the nurses can be reached through their own centers. All it needs is a little coöperation, and assurances of this coöperation have been reaching Headquarters constantly during the past few weeks, describing how the March *Bulletin* has been placed on a library table or a bulletin board, or how it has been read at an alumnae or district meeting.

Institute for State Executive Secretaries

Also designed to be of practical helpfulness was the Institute for Executive Secretaries held March 17–22 at A. N. A. Headquarters in New York City. Discussions, held every morning, centered on problems common to States Headquarters' offices and to programs and objectives. In the afternoons, the executive secretaries visited allied agencies and groups to learn in what ways closer working relationships could be established.

Mrs. Elizabeth P. August was chairman of the Monday morning meeting, at which the purpose of the institute was defined, followed by talks on "The American Nurses' Association, Its Obligations, Programs and Methods." "Administrative Needs and Methods" was the subject Tuesday morning, Margaret Stack presiding. Arabella Creech described budgeting principles, and members of the Headquarters' staff led discussions on bookkeeping principles and office management.

Janet M. Geister, Headquarters' Director, led the discussion Wednesday morning on program building: first, program for the organization and, second, programs for conventions. Caroline Rankiellour was chairman at this session, the second topic of which was "Publicity Principles and Methods."

Thursday morning was of particular interest to the state executive secretaries because on that day state and interstate problems were discussed. Esther Entriken presided at this time and presented a paper on "Transfers," the ensuing discussion being led by Helene G. Lee. "Relations of State Headquarters to Board of Nurse Examiners," was the important subject presented by Eugenia Kennedy, and discussed by Linna H. Denny. The final topic of the morning was "Problems of Maintaining Membership Rolls," presented by Emily J. Hicks, and discussed under the leadership of Mary P. Laxton.

"Group Nursing" and "Registries" were

the topics Friday morning. Sarah F. Martin was chairman at this time; Eleanor Hamilton talked on group nursing; and registries were presented as follows: "Alumnae, District, and Hospital Support of Official Registries," Emma Collins; "Some Practical Problems in Operating Registries," Mary S. Power; discussion led by Angelia P. Lenz; "Hourly Nursing, a Discussion of Tentative Standards for Hourly Nursing," led by Olive Sewell.

Social events for the executive secretaries included a tea, March 16, given by the New York State Nurses' Association, through its Board of Directors; a luncheon, March 17, by the *American Journal of Nursing*, through its editors; and a tea, March 20, by the Henry Street Nursing Service. Among the organizations visited in the afternoons were the National League of Nursing Education, the National Organization for Public Health Nursing, other organizations comprising the National Health Council, the Committee on the Grading of Nursing Schools, the Medical Center, Teachers College, and Cornell Clinic.

Report of the Nominating Committee, 1930

For President; Jane Van De Vrede, Georgia; Mary E. Gladwin, Ohio.

For First Vice President: Elnora E. Thomson, Oregon; Genevieve M. Clifford, New York.

For Second Vice President: Julie Tebo, Louisiana; Jessie Turnbull, Pennsylvania; Mabel Dunlap, Illinois.

For Secretary: Susan C. Francis, Pennsylvania; Claribel A. Wheeler, Missouri.

For Treasurer: Jessie E. Catton, Massachusetts; Shirley C. Titus, Michigan; Mary L. Elder, Iowa; A. L. Dietrich, Texas.

For Directors (three to be elected): S. Lillian Clayton, Pennsylvania; Adda Eldredge, Wisconsin; Clara D. Noyes, District of Columbia; Anne A. Williamson, California; Alta E. Dines, New York; Virginia Martin, Kentucky.

Forty-four states reported; forty-three ballots counted; one ballot rejected for lack of signature.

(Signed) GRACE PHELPS, Oregon, *Chairman.*
ANNE L. HANSEN, New York.
MYRTLE C. APPLEGATE, Kentucky.
EMILIE G. SARGENT, Michigan.
HELENE S. HERRMANN, Pennsylvania.

Amendments to the By-Laws

Proposed amendments to the by-laws of the American Nurses' Association, to be voted upon at the biennial convention in Milwaukee, are as follows. The changes are printed in italics.

ARTICLE I—MEMBERSHIP

Section 1. Membership in this Association shall consist of the active resident members in good standing in the state associations belonging to it; such members of the state associations being registered nurses, graduates of training schools connected with general hospitals giving a continuous training in a hospital of not less than two years, or giving an equivalent training in one or more hospitals. This training must include practical experience in caring for men, women and children, together with theoretical and practical instruction in medical, surgical, obstetrical and children's nursing. (*The training for men nurses must include practical experience in caring for men, together with theoretical and practical instruction in medical, surgical and urological nursing.*) The daily average number of patients shall be that established by the State Nurses' Association in the state from which the applicant comes, for admission to membership.

Sec. 2. An organization desiring to join this Association shall make application on a blank form furnished by this Association and shall send with it a copy of its constitution and by-laws. Such application and constitution and by-laws shall be forwarded to the chairman of the Membership Committee.

Sec. 3. Honorary membership may be conferred by a unanimous vote at any biennial convention, on women who have rendered distinguished service or valuable assistance to the nursing profession, the name having been recommended by the Board of Directors. Honorary membership shall not be conferred on more than two women at any biennial convention.

Sec. 4. A member in good standing in any State Association who changes her residence to another state may be admitted by transfer sent by the Secretary of the State Association she is leaving to the Secretary of the State Association to which she is going, entitling her to membership for the remainder of the fiscal year without further payment of dues.

Sec. 5. Any State Association which fails to comply with the requirements of these by-laws may be dropped from membership by unanimous vote of the Board of Directors, provided due warning has been given at least three months before such vote is taken.

ARTICLE II—OFFICERS

Section I. The officers of this Association shall be a President, a First Vice President, a Second Vice President, a Secretary, a Treasurer, and six Directors. These eleven with the President of the National League of Nursing Education and the President of the National Organization for Public Health Nursing shall constitute a Board of Directors.

(Sec. 2. *The Chairman of the National Committee on Red Cross Nursing Services shall be an ex-officio member of the Board of Directors.*)

ARTICLE III—ELECTIONS

No change.

ARTICLE IV—DUTIES OF OFFICERS

Section 1. The President shall be chairman of the Board of Directors, and Advisory Council, and an ex-officio member of all committees.

(Sec. 2. *The Vice Presidents, in order, shall preside at all meetings in the absence of the President and in case of a vacancy occurring in the office of President, shall assume the duties of President until the office be filled as herein provided.*)

Sec. 3. The Secretary shall keep the minutes of all meetings of the Association, the Board of Directors, and the Advisory Council, preserve all papers, letters and transactions of the Association and have custody of the corporate seal. She shall present to the Board of Directors all applications for membership in the Association, with the report of the Membership Committee on the same. She shall deliver to her successor within one month after the biennial convention, all Association property in her possession.

Sec. 4. The Treasurer shall collect, receive and have charge of all funds of the Association; shall deposit such funds in a bank designated by the Board of Directors, and pay such bills only as shall have been approved by the President. She shall report to the Board of Directors the financial standing of the Association whenever requested to do so and make a full report to the Association at each biennial convention. She shall give a bond, subject to the approval of the Board of Directors, for the faithful performance of her duties. Her accounts shall be audited annually by a certified public accountant approved by the Board of Directors.

The retiring Treasurer shall within one month after the close of the biennial convention deliver to the Treasurer, all money, vouchers, books and papers of the Association in her custody, with a supplemental report covering all transactions from January 1st to the close of the biennial convention.

Sec. 5. All officers except the Secretary and Treasurer shall on expiration of their term surrender all property in their possession belonging to their respective offices to the newly elected President.

Sec. 6. Any one of the eleven officers of the Association, except the President, the First Vice President and the Second Vice President, is eligible to the position of Director of Headquarters or Interstate Secretary.

Sec. 7. Necessary expenses incurred by officers or committees in the service of the Association may be refunded from the general treasury by order of the Board of Directors.

ARTICLE V—BOARD OF DIRECTORS

No change.

ARTICLE VI—ADVISORY COUNCIL

No change.

ARTICLE VII—STANDING COMMITTEES

Section 1. The standing committees shall be as follows:

(a) Revision and Membership
(b) Program
(c) Arrangements
(d) Publication and *Public Information*
(e) Nominating
(f) Relief Fund
(g) Finance
(h) Headquarters

Sec. 2. (*The Revision and Membership Committee shall consist of five members who shall investigate the eligibility of all state associations applying for membership in this organization. It shall devise ways and means for coöperation with state and territories for securing members and report its findings to the Board of Directors, whose decision as to eligibility shall be final. It shall receive all proposed amendments to the by-laws of this Association and submit them for action at the biennial convention. This committee shall also advise state associations concerning proposed amendments to their constitutions and by-laws for the purpose of keeping them in harmony with the articles of incorporation and by-laws of this Association.*)

Sec. 3. The Program Committee shall consist of five members; it shall prepare and arrange the program of papers and discussions and in conjunction with the Board of Directors prepare a complete program for the biennial convention.

Sec. 4. The Arrangements Committee shall consist of five members. The chairman of this committee shall be a resident of the city in which the biennial convention is to be held. It shall make all local arrangements

for the convention and superintend the registration of visitors.

Sec. 5. (*The Publication and Public Information Committee shall consist of five members which shall include the Secretary, the Editor of the* American Journal of Nursing, *and the Director at Headquarters. This committee shall compile a report of the proceedings of the biennial convention, and such other duties as may be assigned to it.*)

Sec. 6. The Nominating Committee shall consist of five members, two of whom shall be appointed by the chair and three by the house.

On or before September 1st preceding the biennial convention this committee shall issue a blank to each State Association belonging to the Association on which blank may be written the name of one nominee for each office to be filled. Blanks from organizations shall be signed by the President or Secretary of the nominating organization and the name of the organization shall be appended.

Blanks shall be returned to the Nominating Committee before January 1st preceding the biennial convention.

From these returns the committee shall prepare a ticket consisting of one or more nominees receiving the highest number of nominations for the office of President, First Vice President, Second Vice President, Secretary and Treasurer, and three or more for the office of Directors. No name shall be presented to a convention, either by the Nominating Committee or from the floor, unless the nominee has consented to serve if elected. This ticket shall be mailed to each State Association at least one month previous to the biennial convention.

Sec. 7. The Relief Fund Committee shall consist of five members, two of whom shall be the Secretary and the Treasurer of the Association. The work of the committee shall be defined by the Board of Directors.

Sec. 8. The Committee on Finance shall consist of the Treasurer and two members appointed by the President. This committee shall make out a budget of expense for the year, advise as to expenditure of funds and report the same to Board of Directors.

Sec. 9. The Committee on Headquarters shall consist of at least three members. The duties of this committee shall be to represent the American Nurses' Association in all its activities in connection with National Headquarters, subject to the approval of the Board of Directors.

This committee may meet with a similar committee of the National League of Nursing Education, or the National Organization for Public Health Nursing, or with both.

Article VIII—Dues

Section 1. The annual dues from each state association shall be fifty cents per capita.

Sec. 2. Dues shall *be paid in advance not later than February 15th for the current calendar year, on the basis of membership, January 31st.*

Sec. 3. *State Associations whose dues have not been paid by March 1st shall be notified by the Treasurer and those not paying by April 1st shall forfeit membership.*

Sec. 4. State associations having forfeited their membership may be reinstated upon the payment of dues for the fiscal year.

Sec. 5. *Dues received by state associations after February 15th shall be paid monthly during each year.*

Article IX—Meetings

No change.

Article X—Sections

No change.

Article XI—Representation

No change.

Article XII—Quorum

No change.

Article XIII—Fiscal Year

No change.

Article XIV—Application of the Term "State"

No change.

Article XV—Duties of State Associations

It shall be the duty of each State Association:

Section 1. To send to the President and to the Secretary of this Association the names and addresses of all officers immediately after their election or appointment.

Sec. 2. To confer with the Committee on Revision before adopting any proposed amendments to their constitution and by-laws.

Sec. 3. To send to National Headquarters a copy of the constitution and by-laws and all amendments adopted.

Sec. 4. *To send to National Headquarters a classified typewritten list of all members with dues as provided in Article VIII.*

Sec. 5. To report to the Board of Directors of this Association as may be required.

Article XVI—Parliamentary Authority

No change.

Article XVII—Official Organ

No change.

Article XVIII—Amendments

No change.

Biennial Convention

The Convention Welcome.—Word comes from the local Committee on Arrangements for the biennial convention of the three national nursing organizations to be held in Milwaukee, June 9–14, that the nurses will be welcomed at the joint opening session of Monday evening, June 9, by the Honorable Walter J. Kohler, Governor of Wisconsin, and by Mayor Daniel Hoan of Milwaukee. Dr. Glenn Frank, President of the University of Wisconsin, will be the speaker at this meeting.

New Arrangements.—As convention time nears, final plans in program and arrangements are being made. The Committee endeavors at each convention to make such new adjustments, based on the experience of preceding conventions, as will add to the smooth machinery of the meetings, and to the comfort of the guests. Here are some of the new plans this year:

1. Meetings will begin promptly and end promptly. The doors of the auditorium will be closed during talks, and late arrivals will wait in the lobby until the conclusion of the address then in progress.

2. The programs will be operated on specific time units, the same in all three organizations. This method, it is hoped, will eliminate confusion as to the time of the various meetings.

These time units call for two morning sessions, the first from 9 to 10.45; the second from 11 to 12.45, thus allowing a fifteen-minute interval between the two meetings. The afternoon sessions will begin at 2.30 and will close at 4.45. From 5 until 6 o'clock is designated as a conference hour, a number of small meetings, round tables, and conferences already having been scheduled. Evening sessions will open at 8.30.

3. There is ample time, it will be noted, between the sessions for luncheons and dinners, Wednesday evening having been designated as an excellent opportunity for holding state dinners and similar functions. Delia H. Newton, Columbia Hospital, Milwaukee, is chairman of the Dinners and Luncheons Committee, through which arrangements can be made. Milwaukee is a hospitable city. It has plenty of hotel space, and is well suited for caring for luncheon and dinner parties.

4. Tickets for all luncheons and dinners will be obtainable from one central table in the convention auditorium. Because of the demands for tickets for such functions which increase at every convention, *no luncheon or dinner tickets will be sold later than one hour in advance of the event, and no tickets will be sold at the door.*

5. If you want your group luncheon or state dinner listed in the printed programs, American Nurses' Association Headquarters must be notified of the event, the time, and the place, before April 25. This date is the absolute "dead line" for program items.

Housing Rules.—From Stella Ackley, Chairman of the Housing Committee in Milwaukee, comes the following:

"A. All reservations for rooms should be made directly to the hotels, not through the Housing Committee. The latter will take care of housing the guests when the hotels are filled, and will make adjustments.

"B. Double reservations and reservations for three or four together will be considered first, rather than single rooms. This is a general rule followed by all hotels."

Registration

Arrangements are being made to have the registration as simple and expeditious a matter as possible, but remember that there are six thousand nurses to be registered. So if you arrive in Milwaukee on Sunday, June 8, will you help yourselves, the other registrants, and those in charge of this work, by registering on that day? The registration booth will be open all day Sunday for this purpose.

Joint Meetings

The three national nursing organizations will meet in joint session as follows:

Monday evening, 8.30, Joint Opening Session.

Tuesday morning, 9–10.45, "Legislation." This topic will be discussed from three angles, General Legislation, Public Health, and Effect on Schools of Nursing.

11–12.45, "Nursing the Community" through the Registry, the Hospital, the V. N. A.

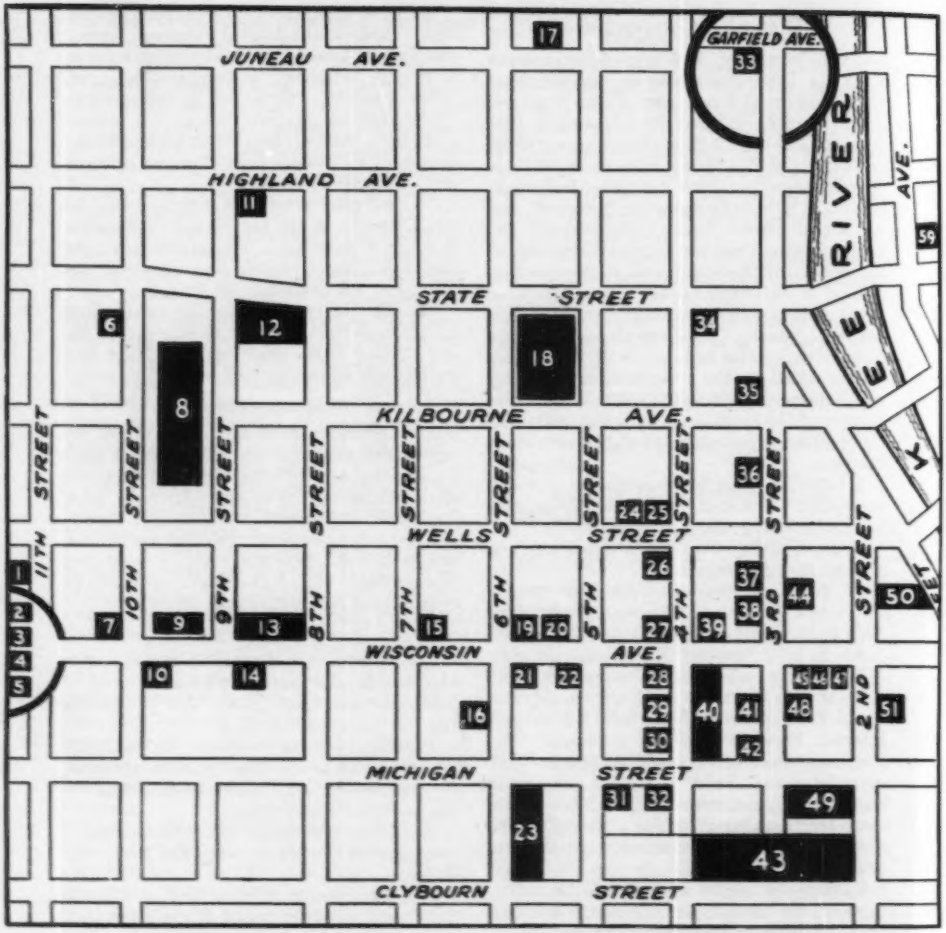
Tuesday evening, 8.30, "Cost of Medical Care" and "Distribution of Nursing Service."

Thursday evening, 8.30, "Newer Developments in Education" and "Their Application to Nursing Education."

Transportation

Transportation—Post-Convention Tours. If you are planning to take a trip after the convention and you wish to avail yourself of the post-convention tours arranged especially for the nurses:

1. *Buy your round trip ticket to the convention, to include this tour.* This will save you a considerable sum as special rates are obtainable in this way. Round-trip tickets for post-convention tours, if purchased separately, do not enable you to avail yourself of the special rates offered in connection with the convention.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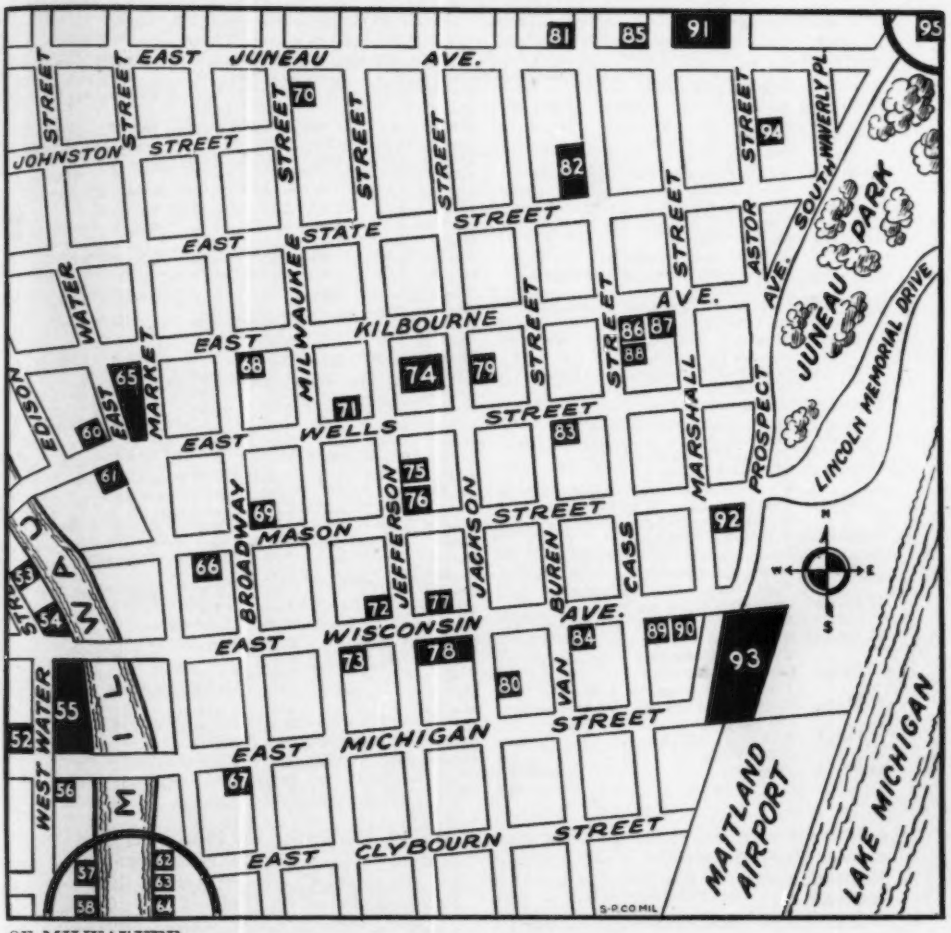
CENTRAL BUSINESS DISTRICT

HOTELS

Abbot Crest (1220 Wisconsin Avenue)	2
Adelin	6
Antlers	51
Astor	91
Belmont	26
Blatz	61
Brown	25
Carlton	70
Colonial	88
Delaware	32
Edison	59
Gilpatrick	36
Globe	89
Juneau	90
LaSalle	1
Martin	84
Maryland	30
McCoy	48
Medford	42
Metropole	24
Miller	37
New Pfister	72
New Randolph	28
Plankinton	52
Plaza	82
Republican	35
Royal	31
Schroeder	22
Schuster's	77
Shorecrest (343 Summit Avenue)	95
Wisconsin	44
Wayland	87

DEPOTS AND DOCKS

Goodrich Docks, Ferry and South Water Streets	63
Grand Trunk Car Ferry, Foot of Stewart Street	62
Public Service Building, Third and Michigan Streets	49
Metropolitan Motor Coach Co.	16
North Shore Depot, Sixth and Michigan Streets	23



OF MILWAUKEE

North Western Depot, Foot of East Wisconsin Avenue	93
Pere Marquette Line Steamer Docks, 68 West Water Street	57
Pere Marquette Car Ferry Docks, Kinnickinnic Avenue	64
Union Depot, Fourth and Everett Streets	43
Wisconsin and Michigan Docks, Broadway and Erie Streets	58
Wisconsin Motor Coach Lines, Third and Michigan Streets	49

OTHER POINTS OF INTEREST

Association of Commerce	50
Athanaeum	86
Auditorium	18
Eagles Club (24th Street and Wisconsin Avenue)	5
Chamber of Commerce Building (Board of Trade)	67
City Hall	65
Convention Bureau	50
County Court House	74
County Court House (Under Construction)	8
Elks' Club	92
Layton Art Gallery and School	76
Milwaukee Art Institute and Museum	75
Milwaukee Athletic Club	69
Milwaukee Herald	15
Milwaukee Journal	34
Milwaukee Leader	17
Milwaukee Motor Club (Twenty-second Street and Wisconsin Avenue)	3
Milwaukee Sentinel	66
Post Office	78
Public Museum and Library	13
Public Safety Building (Under Construction)	12
Scottish Rite Cathedral	83
Tripoli Shrine Mosque (Thirtieth Street and Wisconsin Avenue)	4
Wisconsin News	56
Wisconsin Club	9
Y. M. C. A.	29
Y. W. C. A.	80

LIST OF HOTELS

Distance from Auditorium	*Hotel*		*Without Bath*		*With Bath*		*Suites*
7 Blocks	Abbot Crest—140 rooms and apartments	Single	$1.75		$2.25 to	$ 4.00	
	1220 Wisconsin Ave.	Double	3.00		3.50 "	6.00	$ 8.00 and up
20 Blocks	Ambassador—226 rooms	Single			3.00 "	6.00	
	2300 Wisconsin Ave.	Double			5.00 "	12.00	6.00 " up
6 Blocks	Antlers—450 rooms	Single	$1.00 to	$1.75	2.00		
	130 Second St.	Double	1.50 "	3.00	3.00 "	4.00	
13 Blocks	Astor—1,000 rooms and apartments	Single			3.50 "	5.00	
	266 E. Juneau Ave.	Double			5.00 "	8.00	10.00 to $25.00
2 Blocks	Belmont—116 rooms	Single	1.75 "	2.00	2.75 "	3.00	
	Fourth and Wells Sts.	Double	2.75 "	3.00	3.75 "	4.00	6.00 " 10.00
6 Blocks	Blatz—75 rooms	Single	1.50 "	2.00	2.00 "	3.00	
	E. Water and E. Wells Sts.	Double	2.00 "	3.00	3.00 "	4.50	3.50 " 6.00
8 Blocks	Carlton—100 rooms and apartments	Single	1.50 "	2.50	2.50 "	3.50	
	614 Milwaukee St.	Double	2.50 "	3.50	3.50 "	5.00	5.00 " 7.00
12 Blocks	Colonial—87 rooms and apartments	Single			2.50 "	3.50	
	494 Cass St.	Double			3.00 "	4.00	3.50 " 7.00
3 Blocks	Gilpatrick—115 rooms	Single	1.50 "	1.75	2.00 "	3.00	
	223-225 Third St.	Double	2.50 "	3.00	3.50 "	5.00	5.00 " 6.00
7 Blocks	LaSalle—187 rooms and apartments	Single			3.00 "	6.00	
	117 11th St.	Double			5.00 "	8.50	8.50 " 15.00
12 Blocks	Martin—200 rooms	Single	1.50 "	2.50	2.50 "	3.00	
	201 E. Wisconsin Ave.	Double	2.50 "	3.25	3.50 "	6.00	4.00 and up
5 Blocks	Medford—310 rooms	Single	1.75 "	2.25	2.50 "	3.00	
	Third and Michigan Sts.	Double	2.75 "	3.00	3.50 "	5.50	
4 Blocks	Miller—120 rooms	Single	1.75 "	2.00	2.50 "	3.50	
	175 Third St.	Double	3.00 "	4.00	3.50 "	5.00	
3 Blocks	New Randolph—132 rooms	Single	2.00 "	3.00	2.50 "	5.00	
	Fourth St. and Wisconsin Ave.	Double	3.00 "	4.00	4.00 "	8.00	5.00 to 10.00
10 Blocks	New Pfister—200 rooms	Single	2.50 and up		3.50 and up		
	Jefferson St. and E. Wisconsin Ave.	Double	4.00 "	up	5.00 "	up	15.00 and up
7 Blocks	Plankinton—300 rooms	Single			3.00 to	7.00	
	West Water and Michigan Sts.	Double			5.00 "	9.00	10.00 " up
11 Blocks	Plaza—300 rooms and apartments	Single			2.50 "	4.00	
	551 Cass St.	Double			4.00 "	6.00	
2 Blocks	Republican—200 rooms	Single	1.50 "	up	2.50 and up		
	Third and Cedar Sts.	Double	3.00 "	up	4.00 "	up	6.00 " up
2 Blocks	Schroeder—850 rooms	Single			3.00 to	7.00	
	Fifth St. and Wisconsin Ave.	Double			5.00 "	10.00	10.00 " up
18 Blocks	Shorecrest—250 rooms and apartments	Single			3.00 "	4.00	
	345 Summit Ave.	Double			5.00 "	7.00	8.00 to 20.00
4 Blocks	Wisconsin—460 rooms	Single	1.50 to	2.00	2.50 "	5.00	
	182 Third St.	Double	3.00 "	4.00	5.00 "	10.00	12.00 " 20.00
4 Blocks	Maryland (Double bed)	Single	3.00		5.00		
	(Twin beds)	Double	6.00		5.00		

2. Make your reservation for these tours through any representative of the American Express Company or the Baltimore and Ohio Railroad.

3. A deposit of $25 will ensure your reservation. Final payment must be made at least one week before your departure. Your deposit is refundable on demand.

The American Express Company is offering special rates for the following three personally conducted post-convention tours:

Tour "A"—Leave Milwaukee via Chicago & North Western Ry., Friday, June 13, 10.15 p.m. A visit to Yellowstone Park and the Grand Canyon to include stop-overs in Rochester, Minn. (Mayo Clinic); St. Paul and Minneapolis, Salt Lake City, Colorado Springs, Garden of the Gods, and then return to Chicago, arriving Thursday, June 26, 7 a.m.

Tour "B"—Leave Milwaukee, Friday, June 13, 10.15 p.m., via Chicago, & North Western Ry. A visit to Yellowstone Park and the Grand Canyon, to include visits to Rochester, Minn.; St. Paul and Minneapolis, Portland, Tacoma, Seattle, Lake Louise and Banff Springs, returning to Chicago to arrive Wednesday, July 2, 8.35 a.m.

Members desiring to leave the party at Portland and return via California by rail or canal will be quoted special fares. Members desiring to leave the party and continue to Alaska, or return via Glacier National Park, will be quoted special fares.

Tour "C"—Leave Milwaukee, Friday, June 13, 10.15 p.m., via Chicago & North Western Ry., a visit to Mayo Clinic, Rochester, Minn., on Saturday, June 14. Arrive Chicago, Sunday, June 15, 7.30 a.m.

Members destined for points other than Chicago will leave Chicago by Convention train.

Mrs. C. H. Ray, 2307 Fillmore Street, Amarilla, Texas, Chairman of Transportation for the South Central States, has appointed the following as members of her committee: Mattie L. Davis, 1217 N. Walnut Street, Oklahoma City, Okla.; Edna Peterson, 216 S. Kingshighway, St. Louis, Mo. The Santa Fe route has been chosen as the official route from this section to Chicago and the Chicago, Milwaukee and St. Paul from Chicago to Milwaukee.

The New England States, of which the transportation section chairman is Helene G. Lee, have selected the Boston and Albany Railroad as the official route. Saturday, June 7, is the date the nurses will leave Boston. Connections are to be made at Worcester, Springfield and Pittsfield. The schedule is as follows:

Saturday, June 7:
Leave Boston 9.30 a.m. via Boston and Albany Railroad.
Worcester, 10.40 a.m.
Springfield, 12.02 p.m.
Pittsfield, 1.48 p.m.
Sunday, June 8:
Arrive Chicago 8 a.m. via Michigan Central Railroad. Transfer of train to the Chicago & North Western Ry.
Leave Chicago 10.30 a.m. via Chicago & North Western Ry.
Arrive Milwaukee 12.25 p.m.

Emily J. Hicks, 370 Seventh Avenue, New York City, Chairman of the Transportation Committee for the North Atlantic States, has appointed the following to serve as members of this committee: Margaret Stack, 175 Broad Street, Hartford, Conn.; Mrs. Mae P. Smith, 52 Richardson Road, Richardson Park, Dela.; Sarah F. Martin, 1211 Cathedral Street, Baltimore, Md.; Arabella Creech, 42 Bleecker Street, Newark, N. J.; Esther R. Entriken, 400 North Third Street, Harrisburg, Pa.; Annabelle Petersen, 1337 K Street, N. W., Washington, D. C.

Pennsylvania nurses will travel over the New York Central route. The other states have selected the Baltimore and Ohio Railroad from the east to Chicago and the Chicago & North Western and the Chicago, Milwaukee and St. Paul from Chicago to Milwaukee.

Jane Van De Vrede, Chairman of the Transportation Committee for the South Atlantic States, reports that the following state chairmen have been appointed to serve as members of this committee, also that nurses desiring information as regards selection of routes and special trips following the convention should communicate with state chairmen: Virginia, Juanita Wood, V. N. A., Richmond; West Virginia, Blanche Young, City Hospital, Martinsburg; North Carolina, Agnes Gray, Clinic Hospital, Greensboro; South Carolina, Lila Davis, Sumter; Florida, Mary E. Kavell, St. Luke's Hospital, Jacksonville; Georgia, Margaret Dorn, 1117 Telfair Street, Augusta.

Routes from the southern states: Southern from Atlanta, Ga., to Cincinnati; New York Central, Big Four to Chicago; Chicago, Milwaukee and St. Paul from Chicago to Milwaukee.

Nurses from North and South Carolina and Virginia will join this group at Cincinnati, and those from Florida and south Georgia, at Atlanta.

Mrs. B. L. Cawthorne, Chairman of the Transportation Committee for the Gulf States, Bureau of Public Health, City Health Department, Memphis, Tennessee, has reported: "General routing from the Gulf States territory. All have chosen the Illinois Central to Chicago and the Chicago, Milwaukee and St. Paul from Chicago to Milwaukee, with the exception of east Tennessee, which group will use the Southern to Chicago; those from middle Tennessee will use the Louisville and Nashville to Chicago. Nurses from Kentucky, adjacent to Louisville, will use the Pennsylvania Railway and those in Eastern Kentucky the New York Central Lines."

A. N. A. Program

A feature of the progress of the American Nurses' Association this year will be its emphasis on registries, their problems, and their part to be played in the nursing of the community. There will be two registry round tables, one of these to discuss administrative problems, and one, the problems of the registrant. Other aspects of the program are shaping themselves, the program of the Mental Hygiene Section having been arranged as follows:

Tentative Program for Mental Hygiene Section
Tuesday, June 10, 2.30 to 4.45 p.m.

1. John Anderson, Ph.D., Director, Institute of Child Welfare, University of Minnesota, Minneapolis, "The Nurse's Function in the Training and Guidance of Children."
2. Ruth Gilbert, Mental Health Supervisor, Department of Health, Syracuse, N. Y., "Psychiatric Point of View, a Part of the Nurse's Technic."
3. (Speaker to be announced), "The Functioning of a Mental Hygiene Program in a Visiting Nurse Association."

Thursday, June 12, 2.30 to 4.45 p.m.

Business meeting of section followed by ten-minute papers presented by:

1. Mrs. Ann Howe, Superintendent of Nurses, New Jersey State Hospital, Greystone Park, N. J., "Mental Hospital Affiliations for General Hospital Students."
2. Catherine MacLean, Superintendent of Nurses, Colorado Psychopathic Hospital, Denver, Colo., "Postgraduate and Affiliating Courses given at the Colorado Psychopathic Hospital."
3. Marion Russell, New York State Psychiatric Institute, New York City, "The General Hospital Teaches Mental Nursing."
4. Margaret Daley, Teaching Supervisor, Psychiatric Nursing, Butler Hospital, Providence, R. I., "Application of Classroom Teaching to Ward Activities in a Mental Hospital."
5. Mary D. Taylor, Directress of Nurses, Bloomingdale Hospital, White Plains, N. Y., "Emotional Adjustment of the Student Nurse in Psychiatric Work."

National League Convention Notices

League members are urged to arrive in Milwaukee on Sunday, June 8, and to register that day at the Auditorium. Programs will be given there to each registrant. Voting credentials will be given to members (those who have paid their dues for 1930) at a desk near the general registration. League members will then be ready to vote at the opening business meeting of the League, 9 a.m., on Monday, June 9. We need everyone to help decide on some of the important matters which are before us. By registering Sunday you will avoid the last minute rush of non-League members on Monday morning. Come early and avoid the crowd.

League Program

Monday, June 9

9–10.45, N. L. N. E., opening business session.

11–12.45, N. O. P. H. N., opening business session.

2.30–4.45, A. N. A., opening business session.

8.30–10.15, Joint Session.

Tuesday, June 10

9–10.45, Joint Session.

11–12.45, Joint Session.

2.30–4.45, Open Session Advisory Council, N. L. N. E.

5–6, Conferences:

(a) "Adequate Nursing School Records." Chairman, Stella Goostray.

(b) "Transcripts for Graduate Nurses." Chairman to be announced.

8.30–10.15, Joint Session.

Wednesday, June 11

9–10.45, Session conducted by Education Committee. Topic, "Staff Conferences." Speakers to be announced.

11–12.45, N. L. N. E. Session. Topic, "Selection and Adjustment of Students."

Address, "Selection of Freshmen Students." Speaker to be announced.

Address, "Student Adjustments." Speaker to be announced.

Address, "Selection of Students for a School of Nursing and Problems of Adjustment." Speaker to be announced.

2.30–4.15, Demonstrations by various Milwaukee hospitals.

8.30, Entertainment by Wisconsin nurses.

Thursday, June 12

9–10.45, Session conducted by Instructors' Section. General topic, "Pre-tests." Speakers to be announced.

11–12.45, N. L. N. E. Session. General topic, "Administering Affiliations."

(a) "The Responsibilities and Problems of the School Receiving Affiliating Students," Marian Rottman.

(b) "The Responsibilities and Problems of the School Sending Affiliating Students," Carrie M. Hall.

(c) "The Responsibilities of State Boards of Nurse Examiners in Requiring Affiliations," Adda Eldredge.

2.30–4.45, Round-Table Conferences:

(1) "Selection of Students." Chairman to be announced.

(2) "Value of Extra Hospital Experience in Obstetrics and Pediatrics." Chairman, Helen Wood.

(3) "Extra-Class Activities." Chairman, Shirley Titus.

5–6

8.30–10.15, Joint Session.

Friday, June 13

9–10.45, N. L. N. E. Session. Topic:

(1) "Principles of Supervision and Planning a Supervisory Program." Speaker to be announced.

(2) "Supervision of Clinical Instruction," Mary Marvin, Department of Nursing Education, Teachers College, Columbia University.

(3) Discussion.

11–12.45, N. O. P. H. N., business meeting.

1.30–3, N. L. N. E., business meeting; A. N. A., business meeting.

Overseas Nurses' Get-Together

Wisconsin Unit Women's Overseas Service League is delighted at the thought of greeting Overseas Nurses in Milwaukee. In order not to conflict with state dinners being held Wednesday evening ,June 11, the overseas dinner will take place at the Astor Hotel, Thursday evening, from 5.30 to 8 o'clock (between afternoon and evening sessions of the convention). Tickets will be on sale at the Auditorium, registration day, $2 a plate.

Nurses' Relief Fund

REPORT FOR MONTH ENDING FEBRUARY 28, 1930

Receipts

Interest received on bank balances	$21.50
Interest received on investments	45.00
Contributions	
Alabama: District 7, $34; St. Vincent's Alumnae, $8.40	42.40
Arkansas: State Association	75.00
Arizona: District 1, $27; District 4, $11	38.00
California: State Association	6.00
Colorado: Alumnae Associations—St. Anthony's, Denver, $25; Weld County, Greeley, $17.50; individual contributions, $9; Collected at State meetings, $4	55.50
Delaware: Alumnae Associations—St. Francis, $20; Beebe, $10; Wilmington General, $1; Homeopathic General, $6; Delaware, $20; individuals, $11	68.00
District of Columbia: Graduate Nurses' Assn.	12.00
Illinois: District Associations—No. 1, $100; No. 2, $10; No. 3, $40; No. 4, $10; No. 7, $25; No. 11, $9; No. 14, $10; Alumnae Associations—Chicago Memorial, $20; St. Luke's, $25; Illinois Masonic, $74; Jefferson Park, $10; individuals, $13	346.00
Iowa: Iowa Lutheran Alumnae	1.00
Kansas: District 3	18.00
Kentucky: Jefferson County Graduate Nurses' Assn.	135.00
Massachusetts: Cooley Dickinson Alumnae	10.00
Minnesota: Alumnae Associations—Ancker, $50; St. Lucas, $22; Fairview, $66; Asbury, $85; individual members, $78	301.00
Missouri: District 7, $25; Alumnae Associations—St. Luke's, $250; Jewish, $10; St. John's, $105	390.00
Montana: Nurses' Association of Flathead County	16.00
Nebraska: Alumnae Associations—Lutheran, $6; University, $20; Methodist, $8	34.00
New Hampshire: Eliot Hospital, Manchester	25.00
New Jersey: Alumnae Associations—Morristown Memorial, $15; Paterson General, $115; Mercer, $32	162.00
New York: Frederick Ferris Thompson Alumnae	25.00
North Carolina: State Association	5.00
Ohio: Districts—No. 2, $1; No. 3, $13; No. 4, $98.50; No. 5, $10; No. 9, $75; No. 11, $3.74; No. 12, $163; No. 13, $11; Mercy Alumnae, $40	415.24
Pennsylvania: Pottstown Alumnae	21.00
Texas: Districts—No. 6, $2; No. 12, $154; No. 13, $2; No. 14, $11; No. 15, $42; No. 16, $7	218.00
Wisconsin: St. Joseph's Alumnae, $25; individual contributions, $24.75	49.75
Wyoming: State Association	15.00
Total receipts	$2,550.39
Disbursements	
Paid to 198 applicants	$2,792.00
Salaries	270.55
Postage	20.00
Custodian fee for six months	65.00
Stationery	1.88
Total	$3,149.43
Excess of disbursements over receipts for month ending February 28, 1930	$599.04

All contributions to the Nurses' Relief Fund should be made payable to the *Nurses' Relief Fund* and sent either to the person who collects your dues or to the local Relief Fund chairman. The method for collection of contributions varies in each state. Your district president or treasurer can tell you to whom your checks should be sent. For application blanks for beneficiaries, apply to your own alumnae or district association, or to your state chairman. For leaflets and other information, address the state chairman, or the Director of the American Nurses' Association, Headquarters, 370 Seventh Avenue, New York City.

The Isabel Hampton Robb Memorial Fund

REPORT TO MARCH 12, 1930

Previously acknowledged	$34,776.62
Error in copying treasurer's report	5.00
True amount	$34,771.62
Contributions	
Kentucky: Louisville—Jefferson County Graduate Nurses' Club	$10.00
Maryland: State Association	25.00
Michigan: State Association	25.00
New York: Genesee Hospital Alumnae, Rochester	10.00
Pennsylvania: Hahnemann Hospital Alumnae, Scranton	5.00
Total	$34,846.62

MARY M. RIDDLE, *Treasurer.*

The McIsaac Loan Fund

REPORT TO MARCH 12, 1930

February 11, 1930, Balance	$812.32
Contributions	
Kentucky: State Association	25.00
Maryland: State Association	75.00
Michigan: State Association	25.00
New York: Genesee Hospital Alumnae, Rochester	10.00
Pennsylvania: Hahneman Hospital Alumnae, Scranton	5.00
Interest on loan of February 21, 1929	4.00
Loan of $100 repaid with interest	110.00
Total	$1,066.32
Disbursements	
Feb. 24, Two loans made, $200 each	400.00
March 12, Balance	$666.32

MARY M. RIDDLE, *Treasurer.*

Six scholarships of $300 each are offered for the year 1930–31. Applications must be in the hands of the Secretary before May 1. For application blanks for scholarships or loans, address Katharine DeWitt, Room 1610, 370 Seventh Avenue, New York. Contributions for either fund may be sent to the treasurer at the same address. Please make out separate checks for the two funds.

Army Nurse Corps

During the month of February, 1930, orders were issued for the transfer of members of the Army Nurse Corps to the stations indicated: To Army and Navy General Hospital, Hot Springs National Park, Ark., 2nd Lieut. Ruby Mae Mahon; to Fort Banks, Mass. 2nd Lieut. Barbara A. MacNabb; to William Beaumont General Hospital, El Paso, Tex., 2nd Lieut. Lottie Blackmore; to Fort Benning, Ga., 2nd Lieuts. Antoinette Truchon and Ingeborg M. Dalbotten; to Fitzsimons General Hospital, Denver, Colo., for observation and treatment, 2nd Lieut. Lorene Layne; to Letterman General Hospital, San Francisco, Calif., 2nd Lieuts. Jessie C. Thompson and Genevieve Bergeson, for duty, and 2nd Lieut. Margaret Uthaug for observation and treatment; to Fort Riley, Kans., 2nd Lieut. Ethel Taylor; to Fort Sam Houston, Tex., 2nd Lieut. Freida A. V. Brandiger; to Fort Sill, Okla., 2nd Lieuts. Willie Lee Bond, Dorothy D. Ellis, and Jane Tillinghast Pope; to Fort Slocum, N. Y., 2nd Lieut. Claire E. Pouchee; to Walter Reed General Hospital, Washington, D. C., 2nd Lieut. Mary J. Palmes; to West Point, N. Y., 2nd Lieut. Nellie I. Culliton; to the Hawaiian Department, 2nd Lieuts. Wilma Mae Gross and Anne K. Pilegard; to the Philippine Department, 2nd Lieuts. Elizabeth Barker, Kathleen Mitchell and Mabel A. Watkins; to Headquarters American Graves Registration Service, Quartermaster Corps, 20 Rue Molitor, Paris, France, Captain Blanche S. Rulon.

Twenty have been admitted to the Corps as 2nd Lieutenants.

The following are under orders for separation from the Corps: Katharine M. Bomford, Edna F. Bruntlett, Gladys M. Case, Selina I. Everson, Theresa Fitzgerald, Pauline A. Furminger, Elizabeth J. Grimball, Annette S. Hammersland, Helmi H. Holm, Virginia L. Hubbard, Appa C. Metcalfe, Elsie E. Phillips, Miriam Schmuckli, Daisy M. Sheehan, Hazel A. Tobiason, and Marie L. Turner.

JULIA C. STIMSON,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of January, eight nurses have been appointed and assigned to duty.

The following transfers were made: To Annapolis, Md., Laura M. Nygren; to Great Lakes, Ill., Loretta V. Connor; to League Island, Pa., Florence M. Field; to Mare Island, Calif., M. Ada Allen; to Newport, R. I., Dorothy Apgar; to New York, N. Y., Anna E. Mears; to Pensacola, Fla., Emma L. Hehir, Chief Nurse; to Puget Sound, Wash., Ethel M. DeGarmo, Elizabeth D. Bushong; to San Diego, Calif., Martha H. Velo; to San Diego, Calif. (Hospital Corps School), Kathleen O'Brien, Chief Nurse; to Tutuila, Samoa, Elizabeth Steiner, Grace B. Vestal; to Washington, D. C., Josephine Rugg, Ethel M. Peterson, Katherine E. Kelly.

The following nurse was separated from the service: Olga F. Peters.

J. BEATRICE BOWMAN, R.N.
Supt., Navy Nurse Corps.

U. S. Public Health Nursing Service

The following transfers, reinstatements, and new assignments have been made during February.

Transfers: To Ft. Stanton, N. M., Catherine Winters, Chief Nurse; to Stapleton, N. Y., Muriel Cooper; to New Orleans, La., Willena McPhaul; to Portland, Me., Marion Mayo,

Chief Nurse; to Ellis Island, N. Y., Anna Kollander; to Vineyard Haven, Mass., Ida Holbrook.

Reinstatements: Myrtle W. Neil; Emmaline Hyams.

New assignments: Ten.

LUCY MINNIGERODE,
Supt. of Nurses, U. S. P. H. S.

United States Veterans' Bureau

REPORT OF NURSING SERVICE

Consistent progress in the various projects and varied interests of the nursing service of the Bureau is reported by Mary A. Hickey, Superintendent of Nurses. It is believed that all members of the nursing service greatly appreciate the Nursing Section of the Medical Bulletin. The articles published have been most helpful. To this Section all nurses in the service may contribute material on administrative or technical subjects, as: Ward Management; Nursing Care in Thoracoplastic Operations; A Study of the Care Given to Mental Patients; The Clinic Nurse; What Do Follow-up Nurses Do?; Nursing the Tuberculous; A Study of Follow-up Nursing for Tuberculosis Patients before Hospitalization; Postgraduate Study for Nurses; Common-Interest Problems; Staff Conferences; Doctor, Nurse and Patient. This Nursing Section serves as a channel through which improvements in nursing technic or administration which have been worked out in the various stations in the field may be disseminated to the service at large. Various organizations not connected with the Bureau have expressed interest in the Nursing Section and have reprinted articles of outstanding merit which are of value to the profession.

During the month of February, 1930, the following named nurses were reinstated: Elizabeth McS. Gleason, Cecilia Hermeson, Lila D. Clark, Anna P. Casey, Ellen M. Mallory, Madeline A. Powell, Mary S. Ferrand, Estelle McManus.

Thirty-six new assignments were made.

The following have been separated from the service: Olive Grimsrud, Helen Stafford, Wilbert B. Mead, Bessie Duhorst, Amanda B. Lund, Lydia Coe, Mildred P. Horton, Gladys B. Baird, Mae A. Dreisigacker, Esther P. Curtis, Rose Zorn, Mabel DeLoach, Mary Kreiger, Elsie Hornkohl, Leone Barwiler, Kate Foley, Edna M. Hannon, Goldie Leet.

Orders were issued for transfer of the following named: To Aspinwall, Pa., Mary M. Timmons; to Castle Point, Lina Kidder, Irene Wadsworth; to Ft. Bayard, N. M., Antoinette Montferrand; to Edward Hines Jr. Hospital, Hines, Ill., Mary E. McAuliffe, Thelma Rasmus; to St. Cloud, Minn., Maud Barber; to the Bronx, N. Y., Clara Chapman; to N. Little Rock, Ark., Gracia Braun; to Gulfport, Miss., Nan Sullivan; to Ft. Snelling, Minn., Hannah Erickson; to Palo Alto, Calif., Dorothy Meadors.

MARY A. HICKEY,
Superintendent of Nurses.

U. S. Indian Service

During the month of February the following changes have taken place in the Indian Service nursing personnel:

Appointments: six.
Separations: two.
Transfers: none.

ELINOR I. GREGG,
Supervisor of Nurses.

Program for First International Mental Hygiene Congress

Practically all aspects of mental hygiene will be covered at the Congress, which will be held in Washington, D. C., May 5–10, 1930. Correspondents in many countries have collaborated in working out the program.

American Psychiatric Association and the American Association for the Study of the Feebleminded will hold their annual meetings in Washington at the same time as the First International Congress, and hence the largest number of people interested in mental hygiene ever gathered together at one place and time will probably meet in Washington that week.

It is the purpose to have a maximum of discussion and minimum of formal paper-reading. To this end, papers at the morning sessions, printed at length in advance of the meetings, will be limited to ten minutes in statement, and discussion will follow. Afternoons will be given over to meetings of committees, prepared discussions not on the regular program, recreation, and sight-seeing. General sessions, designed to appeal widely to laymen, will be held on several evenings.

Persons residing in twenty-eight different countries are on the Advisory Committee on Program. Effie J. Taylor, Professor of Nursing, Yale University School of Nursing, represents nursing on the committee.

Some of the important topics, from the nursing point of view, which will be taken up at the sessions are:

Magnitude of Mental Hygiene as a Public Health Problem.
Organization of the Mental Hospital and Its Rôle in Community Life.
Psychopathic Hospitals and Psychiatric Services in General, Medical and Surgical Hospital Practice.
The Teaching of Psychiatry in Medical, Nursing, Social Work and Other Professional Schools.
Syphilis in Relation to Mental Hygiene.

National Conference on Social Work

Methods of combating unemployment and ill health will occupy a prominent place on the program of the fifty-seventh annual meeting of the National Conference of Social Work and its associate groups which occurs in Boston, June 6 to 14. Dr. Miriam Van Waters, referee of the Los Angeles County Juvenile Court, is president of the Conference which is attended by people actively interested in such fields as: health, dependency, delinquency, family case work, neighborhood life, mental hygiene, and economic problems.

The care of chronic disease, and race improvement, are two of the subjects recently announced by Dr. Ira V. Hiscock, of the Yale University School of Medicine, who is chairman of the Conference Division on Health. Dr. Herbert Jennings, of Johns Hopkins University and Dr. T. Wingate Todd, of Western Reserve University will speak on "What Is Practical in Race Improvement." Public responsibility for the provisions of the treatment of chronic disease, and economic problems resulting from such types of disease will be discussed by officials from the Massachusetts State Department of Health.

Information on the Conference may be secured from the Conference office, at 277 East Long Street, Columbus, Ohio.

American Public Health Association

The fifty-ninth annual meeting of the AMERICAN PUBLIC HEALTH ASSOCIATION will be held in Fort Worth, Texas, October 27–30. A real rodeo in its native setting is only one of the things to which delegates will be treated. They will see the best scientific minds of the country wrestling with such subjects as the "Anti-diphtheria Campaign"; "Undulant Fever"; and "Meningitis." These three topics will be made the subjects for joint sessions to be participated in by all the sections of the Association.

Further information will be furnished by the Executive Secretary, Homer N. Calver, 370 Seventh Avenue, New York, N. Y., upon request.

United States Civil Service Examinations

The UNITED STATES CIVIL SERVICE COMMISSION announces open competitive examinations for trained nurse and for trained nurse (psychiatric), applications to be on file not later than April 8, for vacancies in the Panama Canal Service, and also for chief nurse and head nurse (Indian Service), for graduate nurse, graduate nurse visiting duty, and graduate nurse Junior grade, applications to be received until June 30. Information may be obtained by applying to the U. S. Civil Service Commission, Washington, D. C.

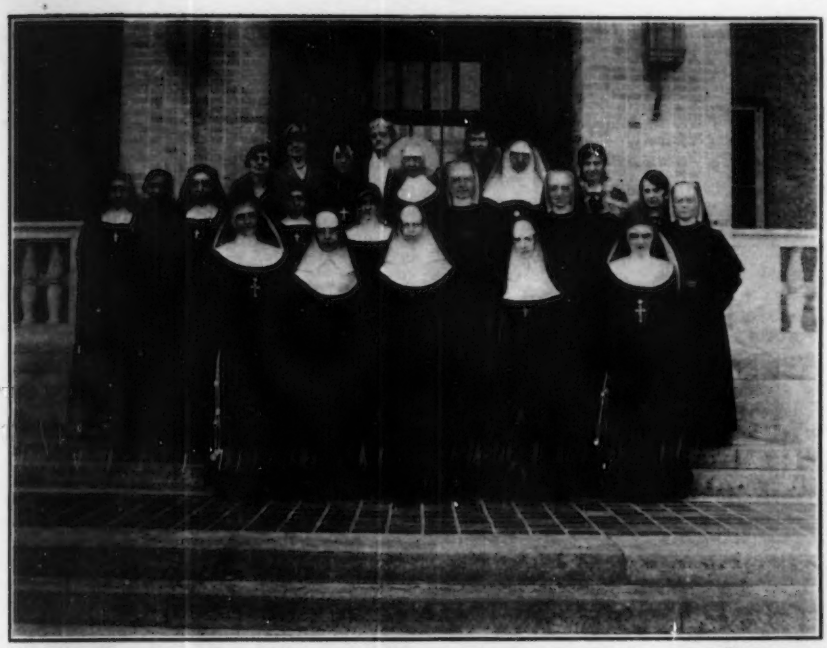
Institutes and Special Courses

Illinois: The INSTITUTE FOR LAY BOARDS OF HOSPITALS AND PUBLIC HEALTH NURSING ORGANIZATIONS, held on February 17, at the Palmer House, Chicago, under the auspices of the Central Council for Nursing Education, offered an interesting opportunity to all those interested in promoting a better understanding of nursing education and nursing service. Board members, nurses, and others interested were present from the five central states.

(The program was published in full in the March issue of the *Journal*, page 355.)

Louisiana: The LOUISIANA STATE LEAGUE OF NURSING EDUCATION will conduct its annual institute at Charity Hospital, New Orleans, April 23 and 24, following the meetings of the Louisiana Hospital Association.

April 23. 8.30 a.m., Registration. 9 a.m., Convening of Institute, Julie C. Tebo, presiding. Invocation, Rev. Matthew Brewster; address by Dr. Arthur C. Vidrine, Superintendent of Charity Hospital; demonstration lesson in anatomy and physiology, Sister Anne, Superintendent of Nurses, Charity Hospital; "Dangers of Indiscriminate Use of Barbituric Acid Drugs," Dr. Oscar W. Bethea, Tulane University; "Correlation of Theory



STUDENTS ENROLLED FOR THE COURSES IN HOSPITAL ADMINISTRATION RECENTLY COMPLETED AT THE COLLEGE OF SAINT TERESA, WINONA, MINNESOTA, BY CAROLYN E. GRAY

and Practice in Teaching Dietetics," Sister Gonzaga, Dietitian of Charity Hospital.

1 p.m., "Student Government," Stella Many, Newcomb College; Round-Table Discussion, Eunice Broussard, Touro Infirmary; Business Meeting.

April 24. Meeting called to order, Anna M. Barr, presiding. Demonstration lesson in nursing technic, Christine Wright, Instructor, Charity Hospital; "Fundamental Principles of Pedagogy," speaker from Loyola University; "A Systematic Program of Staff Education," Mrs. Janette F. Korngold, Superintendent of Nurses, Touro Infirmary; "Our Problems," Julie C. Tebo.

1 p.m., "Method of Teaching Psychology to Students," speaker from Tulane University; "Methods of Increasing Ward Teaching and Improving Supervision," Mrs. C. A. Barney, Our Lady of the Lake Sanitarium, Baton Rouge; "The Case Study Method of Teaching," Mother Henerietta, Mother Superior, Our Lady of the Lake Sanitarium, Baton Rouge.

Minnesota: Winona.—Courses in Hospital Administration offered at the College of St. Teresa, under the direction of Carolyn E. Gray, closed on March 1. Enrollment represented a one hundred per cent increase over that in 1929, when the courses were first introduced. Students enrolled represented eleven different religious communities and seventeen different hospitals, most of them in the middle west, but ranging from Plattsburgh, N. Y., on the east to the Philippine Islands on the west, and from West Virginia in the south to Montana in the north. A certificate of Registration and a diploma from an accredited high school are prerequisites for enrollment in these courses.

New York: The Hudson Valley League of Nursing Education, assisted by the Nursing Division of the Department of Education of the University of the State of New York, is planning an Institute to be held in Troy, April 21–25.

State Boards of Examiners

District of Columbia: An examination for the registration of nurses in the District of

Columbia will be held Thursday and Friday, May 1 and 2, 1930, at Franklin High School, 13th and K Streets, N. W., Washington. Applications must be in the office of Bertha E. McAfee, Executive Secretary, 1337 K Street, N. W., Washington, D. C., before April 15.

Kentucky: An examination for graduate nurses will be conducted by the KENTUCKY STATE BOARD OF NURSE EXAMINERS, in Louisville, at the Brown Hotel, on the 20th and 21st days of May, 1930. All necessary information and applications may be secured by writing to Flora E. Keen, Secretary, Thierman Apartment, C-4, Louisville.

Maryland: The MARYLAND STATE BOARD OF EXAMINERS OF NURSES will hold an examination for State Registration the week of May 5, 1930. All applications must be filed not later than April 15 with the Secretary, Mary Cary Packard, 1211 Cathedral Street, Baltimore.

Missouri: The MISSOURI STATE BOARD OF NURSE EXAMINERS will hold its next examination in St. Louis and Kansas City, April 30 and May 1, 1930.

New Mexico: The NEW MEXICO STATE BOARD OF NURSE EXAMINERS will hold their examinations at St. Joseph Sanatorium, Albuquerque, on May 4, 1930. The Board will meet on May 11 to approve all applications. All graduate nurses who have not registered in this State must have their papers in before this date. The officers of the Board are: Sister Mary Lawrence, President, St. Joseph Sanatorium, Albuquerque; Ella J. Bartlett, Secretary-treasurer, 1601 East Silver Ave., Albuquerque.

South Dakota: The SOUTH DAKOTA STATE NURSES' EXAMINING BOARD will hold an examination for registration of nurses at the Capitol Building, Pierre, May 27 and 28, 1930. For information apply to Mrs. Elizabeth Dryborough, Rapid City.

West Virginia: The WEST VIRGINIA STATE BOARD OF EXAMINERS FOR REGISTERED NURSES will hold an examination for registration on Tuesday, April 29, and Wednesday, April 30, at the Ohio Valley General Hospital, Wheeling, and the New Charleston General Hospital, Charleston. Mrs. Andrew Wilson, Secretary-treasurer.

State Associations

Alabama: Officers of the ALABAMA STATE NURSES' ASSOCIATION are: President, Mattie Huston, Mobile; vice presidents, Helen Stockton, Birmingham, and Ruth Davis, Selma; recording secretary, Margaret Murphy, Mobile; executive secretary, Linna Denny, Birmingham; treasurer, Catherine Moultis, Birmingham. Chairmen of committees are: Ways and Means, Zoe LaForge; Arrangements, Margaret Hutton; Nominating, Anne Beddow; Organization, Leah East; Printing, Lucile Dugan; Publicity, Eloise Vardman; State Relief, Jane Holbrow; National Relief, Bertha McEldery.

Colorado: The COLORADO STATE NURSES' ASSOCIATION held its twenty-sixth annual meeting in conjunction with the twelfth annual meeting of the Colorado League of Nursing Education, at the Antlers Hotel, Colorado Springs, February 12–14, inclusive. About one hundred and sixty-five nurses registered. The meeting was unusually interesting for Janet Geister, Director at Headquarters of the American Nurses' Association, and Mrs. Elsbeth Vaughan, Assistant National Director of the Red Cross Nursing Service, were present through the entire meeting. At the opening session Miss Geister spoke on "What It Means To Belong to the A. N. A.," while Mrs. Vaughan urged increased enrollment in the Red Cross Nursing Service for disaster relief. The chief topics of the convention were the proposed districts for Colorado and re-registration. These were discussed from every angle, including Miss Geister's very helpful presentation of the problems from the viewpoint of the A. N. A. At the close of the discussion it was voted to district Colorado and to draw up an amendment to the Nurse Practice Act to include annual renewal of the registration fee. Following this session, the staff of the Beth-El Hospital presided at a very delightful tea. On Thursday evening, approximately one hundred and fifty nurses were seated at the annual banquet. Friday morning was given over to the program of the Public Health Section, which included a discussion of the study of "The Tuberculosis Problem of Colorado" by a member of the Legislative Committee on that study, and a presentation of the subject of advisory committees and public information in public health nursing programs, by Mrs. Vaughan. There was also a paper presented by a board member of a local organization on "A Board Member's Version of Her Duties and Responsibilities." The Private Duty Section devoted its entire time to a very attractive luncheon at the Glockner Hospital given by the Sisters of Charity and the members of the Colorado Springs Nurses' Association. Both Miss Geister and Mrs. Vaughan

spoke. The entire program of the League was given to Mrs. Vaughan and Miss Geister. Mrs. Vaughan gave a splendid paper on "The Education of the Student Nurse in Relation to Public Health." Miss Geister gave much food for thought in her most interesting talk on "The Economics of Nursing."

Officers elected are: President, Ann Dickie Boyd, 414 14th Street, Denver; secretary, Irene Murchison, Capitol Building, Denver.

State League President, Ellen Perdue, 800 Central Savings Building, Denver; secretary, Ruth Colestock, University of Colorado School of Nursing, Denver.

President Examining Board, Loretto Mulherin, Capitol Building, Denver; secretary, Irene Murchison, Capitol Building, Denver.

Connecticut: The GRADUATE NURSES' ASSOCIATION will hold its next meeting in Meriden on May 15.

District of Columbia: The February meeting of the DISTRICT LEAGUE OF NURSING EDUCATION was held at the National Homeopathic Hospital on February 27. Dr. Reichard gave a very splendid and interesting talk on "Mental Hygiene."

Georgia: The twenty-fourth annual meeting of the GEORGIA STATE NURSES' ASSOCIATION will be held in Atlanta, October 27, 28, 29. Hotel Ansley will be headquarters. Nurses returning from the American Hospital Association in New Orleans by way of Atlanta are cordially invited to attend. If considering please advise headquarters 131 Forrest Avenue, N. E., Atlanta, so that provision for entertainment and participation in the program may be made.

Maryland: The MARYLAND LEAGUE OF NURSING EDUCATION has elected the following officers: President, Elsie M. Lawler; vice president, Helen Shearston; secretary, Frances M. Branley; treasurer, Freda Creutzberg; Executive Board, Margaret Elliott, Marion Crisman, Margaret Belyea.

The INDUSTRIAL NURSES' ASSOCIATION has met four times this year, meetings being held on the second Wednesday of every third month. The meetings have been well attended and very interesting. The purpose of this Association, which is organized as a branch of the Maryland State Association for Public Health Nursing, is to bring together nurses employed in industry. There are forty-three members at the present time. Only graduate registered nurses are eligible for membership. As members of the Maryland State Association for Public Health Nursing, the aim of the organization is to work in accord with its principles. The officers are: Elizabeth Kenly, Chairman; M. Smith, vice chairman; V. Peach, secretary. Many thanks are due Miss Kenly for her efficient and willing service in office.

Massachusetts: The MASSACHUSETTS STATE NURSES' ASSOCIATION will hold its annual meeting, May 17, at the Young Women's Christian Association building, 140 Clarendon Street, Boston. The Public Health and Private Duty Sections will hold meetings on the same day, as also will the Massachusetts League of Nursing Education.

Michigan: The annual meeting of the STATE LEAGUE OF NURSING EDUCATION will be held at Hurley Hospital, Flint, on April 30. The annual meeting of the STATE NURSES' ASSOCIATION will be held at Durant Hotel, Flint, on May 1, 2, and 3. Since the interest of the present day is centering about mother and child care with its attendant legislation, an effort is being made to focus the discussions of the meeting on these subjects.

New Jersey: The annual state convention of the New Jersey nurses will be held at the Winfield Scott Hotel, Elizabeth, April 10–12. The LEAGUE OF NURSING EDUCATION will conduct its business session Thursday morning and a program in the afternoon to be followed by a tea.

Friday morning will be devoted to the business of the NEW JERSEY STATE NURSES' ASSOCIATION and the afternoon program will be devoted to the discussion of nurses' registries from the point of view of the patient, the nurse and the registrar.

At night a banquet will be held under the auspices of the NEW JERSEY ORGANIZATION FOR PUBLIC HEALTH NURSING and Saturday morning the public health nurses will have their business meeting. The Northern New Jersey Federation of Visiting Nurse Associations is meeting in conjunction with the New Jersey Organization for Public Health Nursing.

New York: Presidents' Day. On February 14, the presidents of the fourteen districts of the State Association met for a conference in New York City. The following program was enjoyed: 9.15, Greetings and Welcome, Mrs. Genevieve Clifford, State President; "Machinery and Relationships of our Organization"—(1) "The President," E. J. Hicks, Executive Secretary; (2) "The Secretary," M. Durell, District 13; (3) "The Treasurer," M. Rogers, District 14; "Committees" (appointment, duties, reports, qualifications, accomplishments); 11.20, visit to headquarters offices.

12.30, luncheon given by the *American Journal of Nursing* with an address by Mary M. Roberts on "District Programs." 2.30, "The Grading Committee," Stella Goostray; "What Every Nurse Should Know About Legislation Past and Present," Grace Allison, State Legislative Chairman. 4.30, tea at the offices of the "A. I. C. P."

North Dakota: A CORRECTION.—In the report of the State Association convention, January *Journal*, page 109, the name of Josephine Stennes should be substituted for that of Marceline Buchan, as a director.

Rhode Island: The seventh annual meeting of the RHODE ISLAND STATE ORGANIZATION FOR PUBLIC HEALTH NURSING was held on February 6, at the Medical Library, Providence. Following the regular business meeting, Winifred L. Fitzpatrick gave a report on the meeting of the Revision Committee of the National Organization for Public Health Nursing. Miss McCanna and Miss Shedd, both of Cranston, reported on the coöperation existing between the school nurse and nutritionist. Marie L. Donohoe, Mental Health Supervisor of the Community Health Association, Boston, was the principal speaker of the afternoon; she gave an enlightening account of "Mental Hygiene as Related to Public Health."

South Carolina: The annual meeting of the STATE ASSOCIATION will be held at Spartansburg, April 22–24

Texas: The GRADUATE NURSES' ASSOCIATION OF TEXAS, the LEAGUE OF NURSING EDUCATION and the ORGANIZATION FOR PUBLIC HEALTH NURSING will hold their annual meetings in Beaumont, May 6–9, with the following program:

Tuesday, May 6. Organization of Public Health Nursing, Mary Kennedy presiding. 8 a.m., Registration; Invocation, Rabbi Rosinger; Address of Welcome, Roy Gill, Beaumont Chamber of Commerce; Responses, Clara Hoffman, Red Cross Nurse, Jefferson Co., Sue Nickerson, State Department of Health. 9.45, School Nursing Section, Irma Frenzel, presiding. "Hygiene Work in the Schools," by high school girls and boys. 10.30, "For Sale," Judith Wallen, School Nurse, Abilene; "Oral Hygiene," Dr. G. Sheps; Business session.

12.30, Luncheon, Hotel Beaumont, industrial nurses in charge. 2 p.m., Business session; "County Public Health Nursing and Unit Work," Dr. Barnett, State Health Department; "Texas Children's Code," Mrs. Noyes Smith, President Texas Congress of Mothers and Parent Teachers; "The Nurse as a Teacher of People," Mary Shipp Sanders, Supervisor Rural Education, State Department of Education; "Legal Protection of Children," C. W. Areson, Director of Faith Home, Houston. 7.30 p.m., Banquet at Edson Hotel, special speakers: Dr. T. M. Hunter, Beaumont; Mrs. A. Carpenter, Texas American Legion Auxiliary; Mrs. J. L. Brock, Chairman Brazos County Health Committee; Mrs. A. H. Flickwir, Lay Director, N. O. P. H. N.; E. Moore, Superintendent of Schools, Beaumont.

Wednesday, May 7, Graduate Nurses' Association of Texas. 7.30 a.m., Board of Directors' breakfast. 7.30 to 9, Registration. 8 a.m., Meeting of Advisory Board, Mrs. H. H. Lehman, President, presiding; invocation; address of welcome, Mayor of Beaumont; responses from Districts 10, 11, 13, and 14. Business session with reports of officers, standing committees and delegates. President's address. Paper, "The Economic and Health Aspect of Properly Fitted Shoes for Nurses," Ruby Davis, Dallas.

2 p.m., Private Duty Section, Geneva Landers, presiding. Business meeting, reports of officers and committees; "My Conception of a Private Duty Nurse," Gladys Luckey, El Paso, Dr. Edward Ferguson, Beaumont, and a laywoman; "How Can the Private Duty Nurse Help the Grading Committee?" A. Louise Dietrich, General Secretary. Playlet; round table; "How Can Standard Rates of Charges Be Maintained Throughout the State?" "How To Deal with Patients' Relatives." Election of Officers.

8 p.m., Banquet, District No. 12 hostess.

Thursday, May 9, Mrs. H. H. Lehman, President, presiding. 9 a.m., Invocation, Rev. L. M. Stuckey; Conference for Alumnae Associations; report on I. C. N. and Southern Division meetings, A. Louise Dietrich and others. 12, Red Cross luncheon.

1 p.m., Red Cross business meeting, E. Wallace, Chairman, presiding. Address by Mrs. Myra Cloudman, Field Representative for Texas; playlet by student nurses. 2.30 p.m., Graduate Nurses' Association, business session. 8 p.m., Memorial services for Florence Nightingale, Jane A. Delano and for Texas nurses, under the auspices of the Guild of St. Barnabas, at St. Mark's Episcopal Church.

Friday, May 9. League of Nursing Education, Lucile Burlew, president, presiding. Invocation, Dr. J. H. Pace; "Findings of the Grading Committee," A. Louise Dietrich; "Nomenclature in Different Phases of Nursing Work," Round-table discussion; "Case

Study, Oral and Written," Zora McAnelly; "Graduate Service *vs.* Student Service," Angelica Didier; "Affiliation for Student Nurses," Mae F. Smith, Dallas; "The Forward March of Nursing Schools in Texas," Julia Kasmier; report on Summer School; "Physical Training a Definite Need," Mrs. Curtis Jones; "Necessity of Staff Education in Service," Nina Petrie; "The Bordeaux Hospital," Josephine Dries; "Social Life Made Educational," Mrs. Robert Jolly.

Washington: The WASHINGTON STATE GRADUATE NURSES' ASSOCIATION will hold its annual meeting in Bellingham, May 8–10.

The WASHINGTON LEAGUE OF NURSING EDUCATION met at the Columbus Hospital, Seattle, for its March meeting. Mrs. Frances Willard of the University of Washington spoke on "The Method of Submitting Credentials for the University." Mary Bash, Assistant Dean of Women, spoke on "Scholarship Funds for the University."

Washington State Organization of Public Health Nursing held its quarterly meeting at the Women's Athletic Club in Spokane, January 26. Dr. Barnett was appointed to the Board of Directors. The next quarterly meeting will be held in Spokane, April 7.

District and Alumnae News

Alabama: Birmingham.—The officers of DISTRICT 1 are: President, Mrs. Pansy Reed Barnhart; vice presidents, Mrs. Ross Roberts, Jane Wilson; secretary-treasurer, Alma Whitten; Directors, Helen Stockton, Linna Denny, Zoe LaForge, Lucile E. Dugan, Anice Jackson, Catherine Moultis. **Sylacauga.**—The three units of DISTRICT 7 are now functioning and are making it possible for over fifty members to meet monthly to help each other and to build standards in the training school, private duty and health fields. In each of the three communities the nurses are taking a decided status in the social and civic life. The President of the District has visited each of the units recently, the meeting being held purposely on different days. Meetings of the entire District are held quarterly and it is hoped in time each unit may be strong enough to become a district, as the District territory at present covers seven counties and hundreds of miles. Officers of District 7 are: President, Bertha McElderry; vice presidents, Ferra Mason, Ola Burns; secretary, Ida Bell Crosby; treasurer, Mary Denison. Chairman of committees are: Credentials, Susie McC. Hamilton; Printing, Mrs. Odessa LeCroy; National and State Relief Funds, Mattie Coker; Red Cross, Nellie Bee Emerson; Nominations, Terra Mason; Finance, Mrs. Nell Pady; Publicity, Mrs. Eloise Vardaman.

Colorado: Phoebe M. Kandel, who resigned her position, January 1, as the State Director of Nursing Education, Nebraska, will on June 1 become a member of the faculty of the Colorado State Teachers' College at Greeley. Miss Kandel is entrusted with an unusually interesting piece of work, as she is to direct the administration of the Weld County Hospital and build up a good small school of nursing which will provide a field of practice in teaching and supervision. President Frasier of the College has called upon the Colorado League of Nursing Education for advice in the new project which is being worked out in a most coöperative fashion. By February, 1931, the College will offer an academic program leading to a degree in Teaching, Supervision and Administration in Schools of Nursing.

This semester Miss Kandel is at Creighton University, Omaha, Nebraska, where she is giving courses in "Principles of Teaching" and "Supervision Applied to Nursing Education." She will teach the same subjects at the Colorado State Teachers College during the first quarter of the summer school, June 14 to 19. It is possible that courses in administration will be offered in the second quarter.

Indiana: The INDIANAPOLIS CITY HOSPITAL ALUMNAE ASSOCIATION met on March 8, in the Nurses' Home. Owing to the epidemic of cerebro-spinal meningitis, the Program Committee invited Dr. Smithburn, who has been in attendance on the meningitis ward since the beginning of the epidemic, and who has done special research work with the City Hospital Lilly Laboratory, to address the Association. The discussion following the address was led by Margaret O'Neil and Mrs. Mabel S. Huggins. Five dollars was voted for each of the following funds, the Isabel Hampton Robb Memorial Fund and the McIsaac Loan Fund; also fifty dollars for the Grading Committee. Student nurses were special guests. Thirteen new members were admitted into the Association. Three hundred and seventy-five dollars worth of new furniture had just been installed in the Alumnae Hall, and added much to the comfort as well as interest in the meeting. The next meeting will be on May 10.

Louisiana: New Orleans.—The annual meeting of HOTEL DIEU ALUMNAE was held February 24. The following officers were

elected: President, Asselia M. Logan; vice presidents, Alma Webre, Katherine McCann; secretary, Mary Solazano; treasurer, Mrs. Clara McDonald. Chairman of committees are: Program, J. Berthelot; Nominating, N. Decker; Sick, L. Bock. A rising vote of thanks was given to the retiring president, Mrs. L. H. Cross.

Michigan: Detroit.—An alumnae association has recently been organized at the Paul Lawrence Dunbar Hospital and has been accepted into membership by the Detroit District. Gertrude Morton has been appointed a supervisor on the Detroit Visiting Nurse Association Staff in charge of the Hamtramck Branch. The branch is unique in Detroit in that it carries on clinic work for women and children with a generalized program of field nursing. **Grand Rapids.**—The Alumnae Association of Blodgett Hospital celebrated its twenty-fifth anniversary on the evening of March 3. Sixty members of this Association, which is the third oldest in the State, were served a buffet supper in the students' dining room. St. Mary's Hospital Alumnae Association met for dinner on the evening of March 4. Eighty members were present. Various district and alumnae problems were discussed. **Lansing.**—The St. Lawrence Hospital entertained the Lansing District on March 3. Judge C. B. Collingwood gave an address on "Juvenile Delinquency in Michigan."

Missouri: Kansas City.—The following officers of DISTRICT 2 were elected at a meeting held February 5, at the Nurses' Club House, 4343 Oak Street: President, Florence Peterson; vice presidents, Virginia Mosley, Grace Frauens; secretary, Elizabeth Martin; treasurer, Zola Lumbeck. **Springfield.**—The officers of ST. JOHN'S ALUMNAE, recently elected, are: President, Pauline Monpleasure; vice president, Mary Ryan; secretary, Margaret Thiel; treasurer, Ruth Wade; and chairman of Entertainment Committee, Mary Fellin. **St. Louis.**—The THIRD DISTRICT held its annual meeting, January 20, at the Central Club. Officers elected are: President, Bertha O. Yenicek; vice presidents, Edith Hunter, Rose Walker; financial secretary, Mabel Gray. A new advisory committee has been organized for the Central Directory comprising three members from each Section. The chairman is Ruth Cobb. Grace G. Grey, Superintendent of Nurses at the Jewish Hospital, has severed her connection with that institution. She is succeeded by Edna Peterson. The MISSOURI BAPTIST ALUMNAE ASSOCIATION has 250 members and holds meetings the first Friday of each month, except July and August. Officers elected at the annual meeting in January are: President, Caroline K. Bode; vice presidents, Ruby W. Forsen, Katharine Hart; secretary, Eunice Stone; treasurer, Anna Jane Smith. The alumnae furnished a room in the new addition to the hospital which was the first donation. The addition gives one hundred more beds, and it is modern in every way. The Association has also contributed $95 to the Bordeaux Fund; $320 to the Nurses' Relief Fund, $250 to legislative work, and $1,241 to State Headquarters. A representative was sent to the International meeting in Montreal. Two student nurses were sent to the State Convention by the student body. At their February meeting, the members of the ALUMNAE ASSOCIATION OF WASHINGTON UNIVERSITY SCHOOL OF NURSING enjoyed a talk by Alice Maull, who is at home for a year on leave of absence from her position as Superintendent of a School of Nursing in Manila.

Nebraska: Omaha.—ST. JOSEPH'S HOSPITAL SCHOOL OF NURSING entertained the local League of Nursing Education on February 22. The Senior students put on a Forum, using the work of the Grading Committee as a basis for the discussions. Materials used in preparing for the discussion were *Nursing and Nursing Education in the United States* (the so-called Goldmark Report); *Nurses, Patients and Pocketbooks;* various reprints from the *Journal;* and the National League of Nursing Education reports.

New Jersey: Newark.—The annual meeting of the NEWARK CITY HOSPITAL ALUMNAE ASSOCIATION was held on February 27, at the Nurses' Home. The officers are: President, Mrs. Virginia F. Gibbs; vice presidents, Grace E. McVey, Miss DuBusc; secretary, B. Schilling; treasurer, Miss Heide. Announcement was made by the Superintendent of Nurses, Caroline Schmoker, that there will be a reunion in the fall to which all graduates are invited, whether alumnae members or not. The date of the reunion will be announced later. The annual meeting of the alumnae of the NEWARK MEMORIAL HOSPITAL was held at the Nurses' Home, recently. The following officers were elected: President, Anna Thomas; vice president, Mrs. Feltrup; secretary, Effie Thomas; treasurer, Florence Pierce. The March meeting of DISTRICT 1 was held at the Academy of Medicine, on March 4. Most of the evening was given to the Red Cross, Helen Stephen, State Chairman of the Red Cross Nursing Service, in charge of the meeting. Ida F. Butler,

Assistant to the Director of the National Red Cross Nursing Service, gave a splendid talk on "The Ideals and Vision of the Red Cross," commemorating the death of Jane A. Delano, Director of the Red Cross Nursing Service during the War. There were about four hundred nurses present, mostly in uniform, about two hundred and fifty of whom were students.

New York: Binghamton.—DISTRICT 5 held a meeting, on March 3, at the Binghamton City Hospital, Ida McAfee, presiding, and fifty nurses in attendance. Emily J. Hicks, Executive Secretary of the State Association, gave a most interesting talk on nursing affairs in the State. Her discussion on nursing problems should have been helpful to every nurse present, and her advice and counsel were most stimulating. **Ithaca.**—The ITHACA MEMORIAL HOSPITAL ALUMNAE, at their January meeting, elected: President, Clara M. Woolsey; vice president, Bernice Howland; recording secretary, Edith Howland; corresponding secretary, Sydnie Hall; treasurer, Frances Tyrell. It was an interesting meeting, held at the Community Building with thirty-three present. On March 5, Emily J. Hicks, State Executive Secretary, gave a most helpful and inspiring talk to students and alumnae. **New York.**—The NEW YORK LEAGUE OF NURSING EDUCATION, SECTION 1, held a meeting on March 5, in the Administration Building of Henry Street Settlement. This was the fourth in the series, "The Improvement of Nursing Practice." Gertrude Wahl of the Visiting Nurse Service spoke on "The Application of Nursing Practice to Home Situations," with demonstrations. There was a good discussion of the employment of general duty nurses and of educational programs for them, led by May L. Crouch. MOUNT SINAI HOSPITAL held commencement exercises for a class of seventy-six on March 6. The address was given by Dean M. C. Winternitz of New Haven. **Rochester.**—The GENESEE VALLEY NURSES' ASSOCIATION held a meeting at the Club House on February 25, with a program arranged by the private duty nurses. The ROCHESTER GENERAL HOSPITAL ALUMNAE held a meeting at the Nurses' Home on March 3. Hazel Gammon gave a demonstration on "Keeping up to Date in Nursing Procedures." The GENESEE VALLEY HOSPITAL ALUMNAE held their annual meeting on January 6 and elected: President, Mrs. Fred Ratcliffe; vice presidents, Mrs. Arthur Reed, Dorothy Glazier; recording secretary, Beatrice Richardson; corresponding secretary, Ruth Clements; treasurer, Mary Harriman. Chairmen of committees are: Allerton Memorial, Jessica S. Heal; Welfare, Mrs. Marcella Moore; Friendship, Clyde Irwin; Nominating, Mildred Stanbrook; Program, Adelaide Bickford; Nurses' Relief Fund, Laura Bradfield. At the March meeting, Dr. Stanhope Bayne-Jones spoke on "Microbes."

North Carolina: District 1, Asheville.—The meeting on February 12 included a short memorial service in honor of Athalia Lord, a beloved member who passed away on January 29. The Program Committee presented Miss Kelley's interesting report of the meeting of the Southern Division in Birmingham, Ala. **District 2, Winston-Salem.**—The meeting was held on February 13. The *Journal* Committee reported nine new subscriptions to the *American Journal of Nursing*. Mrs. Henry Roan gave a delightful talk on "My Trip to the Holy Land." The ALUMNAE ASSOCIATION OF THE CITY MEMORIAL HOSPITAL reports a very enthusiastic February meeting. Plans are being made for an endowed room for sick nurses in the City Memorial Hospital. BAPTIST HOSPITAL ALUMNAE ASSOCIATION held a meeting at the hospital, February 8. A talk on "Nursing History," with lantern slides, was contributed by Hettie Reinhardt, Instructor in the School of Nursing. **District 3, Charlotte.**—The February meeting was held in the Medical Library, when Dr. Phillips gave a fine address on the "Uses of Radium and X-Ray." The DAVIS HOSPITAL ALUMNAE ASSOCIATION, Statesville, was admitted to District membership. ST. PETER'S HOSPITAL ALUMNAE ASSOCIATION reports much activity. An interesting feature of a recent meeting was a paper by Edith Redwine, Instructor in the School of Nursing, on "How to Improve Our Alumnae Association." The MERCY HOSPITAL ALUMNAE ASSOCIATION reports a revision of the constitution and by-laws, also a good meeting in which a discussion of Miss McCormick's article, "The Open Door of Opportunity," was a prominent feature. The ALUMNAE ASSOCIATION OF THE CHARLOTTE SANATORIUM has also finished a revision of its constitution and by-laws. The PRESBYTERIAN HOSPITAL ALUMNAE ASSOCIATION reports a revision of constitution and by-laws and increasing interest. **District 4, Greensboro.**—The Greensboro nurses have issued an attractive yearbook. Dates of meetings with programs for the year are arranged. Lists of officers, standing and special committees, names, addresses and telephone numbers of all members are also included. The Yearbook carries a copy of the District constitution and by-laws. **District 5, Durham.**—The program for the February meeting

was in charge of the Public Health Nurses. Dr. J. H. Epperson, of the County Board of Health, gave a most instructive talk on "A General Health Program." **District 6, Raleigh.**—At the February meeting, Miss Kelley's report of the meeting of the Southern Division was read and discussed with much interest. Nellie Roop of Rex Hospital contributed an excellent paper on "Nursing Education." Rose Thayer, a former member, spoke of the educational work being done in California. The application of the Rex Hospital Alumnae Association for District membership was accepted. **District 7, Fayetteville.**—On February 5, the DISTRICT ASSOCIATION was entertained by the Highsmith Hospital Alumnae Association. Lula West, State Educational Director, was present and gave a clear outline of the standards which the State is trying to uphold in the schools of nursing, and the influence of these requirements on the future of the nursing profession in the State. Following Miss West's address a preliminary student, dressed as "Sairy Gamp," gave an outline of Nursing History and compared her costume with that of the modern nurse in uniform. The program continued with demonstrations in Practical Nursing by preliminary students. The demonstrations were those which were presented before the School Committee when the students were accepted. The Highsmith Hospital Alumnae is collecting material of historical value to the school to be placed in a school museum. **District 7** held its regular monthly meeting in Sanford on February 12. After the usual business a paper, "What the Medical Doctor Thinks of the High Cost of Medical Care," was read by Miss Kelley. Other papers from the *Survey Graphic* were read: "What the Business Man Thinks of the High Cost of Medical Care"; "The High Cost of Nursing"; "Medical Facilities in the United States." Dr. F. L. Knight showed some very interesting x-ray pictures. The application of the Baker Sanatorium Alumnae Association for District membership was accepted. The ALUMNAE ASSOCIATION OF THE BAKER SANATORIUM held its monthly meeting in Lumberton on February 15. An address by the President, Margaret Brown, on "What an Alumnae Has To Offer," was interesting and valuable. The article on "State Standards" by Ethel Smith, in the *American Journal of Nursing*, was read and discussed. **District 9, Wilmington.**—The regular meeting was held February 12, in the Nurses' Home, James Walker Memorial Hospital. Mr. Fisher, Superintendent of the Hospital, and Mr. Eliot, a member of the Board of Managers, discussed matters relative to the rules for special nurses in the hospital and other affairs of mutual interest in connection with the Registry with a view to promoting coöperation and efficient service. The JAMES WALKER HOSPITAL ALUMNAE ASSOCIATION reports a year of active interest and work. Two competing teams headed by enthusiastic captains assured large attendance at all meetings.

Ohio: Ashtabula.—When the gift of $75,000 was presented to the ASHTABULA GENERAL HOSPITAL for a new Nurses' Home, the alumnae planned to furnish one or two rooms. The Association, of which there are 114 members, active and non-active, was divided into twelve groups. The groups in turn, were to do something each month to raise money. Some of the groups gave card parties and dances. Others held rummage and bake sales. At the regular monthly meeting, held February 7, a check for $1,200 was presented to Clara A. Fisher, Superintendent of the Hospital, by Mrs. Jennie Burkhardt, Ex-President of the Alumnae Association. The first meeting in the new Home was on February 13, when Dora M. Cornelisen spoke on the "Value of the *Journal*." **District 1** held its regular monthly meeting in Canton, March 10. Karl Berns, Principal of West Normal School, was the speaker. **District 2** met, January 25, in Bellaire. The Public Health Section was in charge of the program. Miss Clayton, County Health Nurse, spoke on "The School Nurse and the Community;" Doratha L. Kern led the discussion of the topic, "Are There Too Many Nurses?" **District 4** held a meeting March 18. Edwin Baxter, Vice President of the Cleveland Trust Co., talked on "A Reasonable Financial Program for Women." The Section on Nursing Education held a meeting, March 12, and Nina D. Gage, Executive Secretary of the N. L. N. E., spoke on "Nursing School Records." **District 6** held a meeting Tuesday, March 11, in Good Samaritan Hospital, Zanesville. Student nurses of the local hospitals were guests. Mrs. Elizabeth P. August spoke on the Nurses' Relief Fund, Ohio Emergency Fund, Harmon Foundation, Annuities for Nurses, the Work of the Grading Committee and the *American Journal of Nursing*. **District 8** held a meeting in St. Mary Hospital, February 24, when Milton B. Campbell spoke on "Child Welfare Work in the American Legion." The Section on Nursing Education meeting was attended by fifty nursing executives in Cincinnati. **District 9.**—The Toledo District Nurse Association furnished the program for the regular monthly

meeting, March 19. Dora M. Cornelisen, Director of the American Nurses' Association, and Field Representative for the *American Journal of Nursing*, was the guest of honor and speaker at a dinner given by District 9, in Woman's City Club, February 27. Miss Cornelisen talked to members of the various nurses' training schools, which included Mercy, St. Vincent's, Robinwood, County, Women's and Children's, and Flower hospitals. District 12 held its regular monthly meeting, March 5, at Mercy Hospital Nurses' Home. Rabbi Tarshish spoke on "How To Be Happy." District 13 held a meeting in City Hospital, Lima, March 3, with fifty-five members present. Dr. Harry Noble of St. Mary's, Ohio, gave an inspirational talk on "The Nursing Profession, Old and New." Miss Cornelisen, Field Representative of the *American Journal of Nursing*, addressed the nurses. Plans for the Ohio State Nurses' Convention, to be held in Lima April 21–24, were completed.

Pennsylvania: Bethlehem.—The annual meeting of DISTRICT 2 was held at the Nurses' Home of St. Luke's Hospital. The following officers for the year 1930 were elected: President, Ada Snyder; vice presidents, Agnes Dillon, Bessie M. Ely; secretary, Lucy Gray Tenaglia; treasurer, Emma J. Heister. **Nanticoke.**—The NANTICOKE STATE HOSPITAL NURSES' ALUMNAE ASSOCIATION held its monthly meeting at the Nurses' Home on March 7. The Superintendent, Mrs. A. MacLaren, read several articles of interest from the *American Journal of Nursing*. **Philadelphia.**—At the annual meeting of the ALUMNAE ASSOCIATION OF THE HOSPITALS OF THE GRADUATE SCHOOL OF MEDICINE the following officers were elected: President, Anna L. Meier; vice presidents, Mrs. Inez D. Whipps, Anna Barrett; secretary, Elizabeth A. Deeds; treasurer, Ruth M. Class.

Washington: Bellingham.—DISTRICT 1 elected the following officers for the coming year: President, Ivy Gibbs; vice president, Ida Falconer; secretary, Dorothy Swartz; treasurer, Mabel Simpson. **Seattle.**—DISTRICT 2 held its March meeting at the Henry Building. Professor E. A. Bishop of the School of Education at the University of Washington spoke on "Social Education." His talk was enjoyed and appreciated by the group.

West Virginia: Bluefield.—At its regular meeting, held February 7, the BLUEFIELD SANITARIUM ALUMNAE ASSOCIATION elected: President, Mrs. Edith Williams; vice presidents, Mary Austin, Gertrude Fisher; secretary, Faye Miller; treasurer, Cora Wilson.

Too Late for Classification

Arkansas: The ARKANSAS STATE BOARD OF NURSE EXAMINERS will hold its semiannual meeting in the House of Representatives, Capitol Building, Little Rock, May 1, 2 and 3. Ruth Riley, Secretary.

Indiana: The INDIANA STATE BOARD OF EXAMINATION AND REGISTRATION OF NURSES will hold the semiannual examination in the State House, Indianapolis, May 7 and 8. Lulu V. Cline, Secretary.

Michigan: The MICHIGAN BOARD OF REGISTRATION OF NURSES has moved its offices to 314 United Building, Lansing.

Texas: The BOARD OF NURSE EXAMINERS FOR THE STATE OF TEXAS has moved its office to 609 Milam Building, San Antonio.

Deaths

Amy Allison (class of 1903, Pennsylvania Hospital School of Nursing, Philadelphia), on February 28, at the Good Samaritan Hospital, Lexington, Ky., after an operation for ruptured appendix. Miss Allison was a Canadian, born at Dunbarton, Ontario. She held a B.S. degree from Teachers College. She had a broad experience of life and work in many parts of the country—in Minneapolis, in Alberta, Canada, in Virginia and in Omaha. She was a born teacher and, after her course at Columbia, she was well qualified for her chosen work, instructor of nurses. She held this position for several years at the Rhode Island General Hospital. In 1924 she removed to Philadelphia, where she was Superintendent of Nurses at the Municipal Hospital until last August. Here, busy and devoted as she was, her work by no means was limited by hospital walls. She was a loyal member of her Alumnae Association and of the State and National Associations, attending the conferences to which she contributed several valuable papers. She worked tirelessly in helping to build and carry on the Philadelphia League of Nursing Education. She was also a member of the Woman's City Club and had many outside interests. In October she went to Lexington to become Superintendent of the Hospital, where she died.

There was no one in the world like Amy Allison. Brave, strong, courageous spirit, adaptable and progressive, but uncompromis-

ing in vigorous honesty and lofty principles, always helpful, always dependable, she stood, a tower of strength and righteousness. She always did all that she should have done, and then much more. She gave of herself without stint, entering helpfully into the lives of her nurses, giving up her holidays to make the days brighter for them, unfailingly courteous and thoughtful with patients and the anxious friends of patients, often hospitably caring for them in her own rooms, struggling to make things cheery and homelike under most discouraging circumstances, carrying all on her own broad shoulders. No one knows how wide have been the circles of her influence, but she has left a world the richer for her brave, strong life.

Laura Muriel Boyden (class of 1919, House of the Good Samaritan, Watertown, N. Y.), on February 27, at Sonyea, of a complication of diseases. Miss Boyden took a postgraduate course at the Sloane Hospital, New York, but, owing to illness, had not been practicing for nine years.

Helen Buckner (class of 1927, Washington University School of Nursing, St. Louis, Mo.) in Los Angeles, January 22.

Amelia E. Crockett (class of 1924, Ashtabula General Hospital, Ashtabula, O.), on March 5, at a sanitarium in White Haven, Pa., following an illness of a few days from pneumonia. After her graduation, Miss Crockett enrolled at Mount Ida School, near Boston, Mass. A month after her entrance she became ill. Since that time, a constant but losing struggle had been waged to save her life.

Mary A. Cunningham (class of 1912, Trinity Hospital School of Nursing, Milwaukee, Wis.), on February 19, at the Research Hospital, Kansas City, Mo., where she was surgical supervisor. Miss Cunningham had been in Kansas City since 1914, being an active member of the Second District Association and of the Kansas City League of Nursing Education. Memorial services were held at the Nurses' Club House on March 5. Burial was at her home in Neseda, Wis.

Elsteth Dempster (graduate of Orange Memorial Hospital, Orange, N. J., and Polyclinic Hospital, New York), on February 6, at Community Hospital, Montclair, N. J.

Pearl Dibert (class of 1921, Altoona Hospital, Altoona, Pa.), on March 2, in Altoona Hospital, following an operation. Miss Dibert had done private duty nursing since graduation. Her life was devoted to unselfish service to others. She was a faithful nurse, a sincere friend and she will be missed by all who knew her.

Mrs. Almeda Brown Haning (graduate of People's Hospital, Akron, O.) on February 28, at Springfield Lake Sanatorium, where she had been ill for the past year.

Mrs. Esther Hanson (class of 1929, Washington University School of Nursing, St. Louis, Mo.), on February 26.

Pauline Hashagen (class of 1926, St. Luke's Hospital, Spokane, Wash.), at Missoula, Mont.

Mrs. Adelaide F. Hughe McGrath (class of 1896, Charity Hospital, New Orleans, La.), on January 19, of heart trouble. Mrs. McGrath was Superintendent of Nurses at Charity Hospital from 1898 to 1906, and afterward a successful private duty nurse until her marriage in 1908, when she moved to Alabama. She kept in close touch with the nursing profession, although not actively practicing except in emergencies. Her Christian spirit has gone to its reward, but many loyal friends will miss her guidance, and the profession a true nurse.

Ruth Wade (class of 1919, St. Mary's Hospital, Walla Walla, Wash.), on February 12, at the Valley General Hospital, Walla Walla, following a short illness. Miss Wade was active in her professional group and will be missed by a wide circle of friends.

About Books

TEXTBOOK OF WARD ADMINISTRATION. By Gladys Sellew, R.N. 290 pages. Illustrated. W. B. Saunders Co. 1930. Price, $2.75.

A VERY significant aim seems to run through all of the *Textbook of Ward Administration:* namely, an attempt to get at definite and objective ways of measuring nursing, of clarifying the present vague conception of what ideal nursing is, of finding standards by which nursing service may actually be judged, of discovering exactly what is involved in giving nursing care to a patient, of planning to make the most of such nursing service as is available. Over and over the author points out the fallacy of expecting to have done in a given time an amount of nursing care hopelessly impossible with the staff at hand; of expecting students to approach the standard of work set in the classroom under the conditions prevalent in some wards. The main interest of the book lies in the fact that the author is trying to show how these hazy ideas about nursing may be brought into clearer focus by reducing them to figures and facts.

To this end there are presented a number of devices for getting at the facts. There are some very interesting time studies, procedure sheets written out in detail, suggestions for determining the number of floor-duty nurses required in a given ward, and the number of hours of nursing service needed at stated hours of the day, plans for the daily ward routine, and the like.

Discussion of the relation of the school of nursing to ward administration is also included. Analysis of the practice field is considered as the first step in planning the ward experience of the student. Consideration is also given to the experience which the student should receive in a given service, to ways of relating theoretical work to ward practice, to records, to case study, and to several other ward-teaching methods. These last are, however, not discussed in much detail. One feels that the problems of ward administration have been gone into more thoroughly than those of ward teaching.

There are several points at which one might differ with the author, for instance as to whether the list of medical cases with which the student should have experience should be compiled from textbooks on medicine or from an analysis of actual hospital wards. Again one might feel it necessary to go even further in making a time study, and analyze the procedures more minutely. One might wish for a clearer picture of the functions of the head nurse and more complete discussion of teaching methods on the ward. However, there is much that is definite, concrete, and helpful in the book, and perhaps its greatest service will be to stimulate those who are already searching for ways by which we may achieve that tenuous and intangible something which we now loosely refer to as "good nursing."

H. W. M., R.N.

STUDY GUIDE TEST-BOOK IN ANATOMY AND PHYSIOLOGY. By Carolyn E. Gray, A.M., R.N. 179 pages. Illustrated. The Macmillan Company, New York. 1930. Price, $1.10.

WITH the appearance of *The Study Guide Test-Book of Anatomy and Physiology*, by Carolyn E. Gray, we have an aid to the teaching of this subject which will be warmly welcomed throughout the nursing world.

Testing is an important part of teaching. This is especially true of a subject like Anatomy and Physiology, where there is such a mass of detail to be memorized. With the limited amount of time available and because the old type of testing consumes so much time, this phase of teaching is often neglected and the teacher does not learn until too late that the student has not the grasp of the subject which she should have.

This new test-book is composed of test exercises printed on perforated sheets with blank spaces for the answers. The exercises follow quite closely the text of the Kimber-Gray *Anatomy and Physiology*, but there is no reason why they should not be used in conjunction with any other text.

The book is designed, through a continued use of these exercises, to help the teacher to detect early and to diagnose any difficulties the student may have in interpreting the text, and also to provide a means of expression for the student, which is an important factor in learning.

There is considerable variety in the type of exercises used which should help to relieve the monotony of testing. Some exercises are composed of questions of the completion type, some of the multiple choice type, and some of the essay type. But, whatever the kind of question used, each exercise is designed to emphasize the important points in the particular part of the text to which it relates. The questions are of the thought-stimulating type and are so formulated that they can be answered in a few words. This is one of the most valuable features of the book, for through it the author aims to conserve the time of both the student and the teacher. Some exercises ask that the answers be given in table form and some are devoted to the labeling of pictures which have been copied from the text-book. This last type of exercises should furnish an incentive for the student to study more carefully the illustrations, which are an aid in clarifying obscure points as well as to memory.

As a study guide the most important function of the book would seem to be to suggest examples of problems which the student should see in the text. Problem-solving is acknowledged to be one of the most economical forms of study, but the young student often has difficulty in formulating these for herself. The *Study Guide Test-Book*, which furnishes good examples of problem questions, should help her to see a succession of problems in the assignment.

For the young teacher who has not yet learned the fine art of testing, and for the busy teacher who does not have time to prepare a variety of searching questions, so well illustrated here, this test-book should be an invaluable aid.

HARRIET M. GILLETTE, R.N.
New York.

PRESCRIBING OCCUPATIONAL THERAPY. By Dr. William Rush Dunton, Jr. 144 pages. Thomas Company, Springfield, Ill. 1928. Price, $2.10.

THIS book was written for physicians and medical students, but nurses will read it with great profit.

The author is one of the foremost authorities on occupational therapy. He has spent many years in its application to disease; has written several books on the subject and is the editor of *Occupational Therapy and Rehabilitation.*

Brevity has been stressed so that the subject may be quickly apprehended. Excellent and numerous references for those who desire further information add greatly to the value of the book which is divided into two parts: Part I, General Principles; Part II, Special Application. In Part I, Significance, Prescription, and Fatigue are discussed. In Part II, the special application of occupational therapy to various types of mental, medical, surgical, orthopedic, cardiac and tuberculous disorders is very well presented. A special chapter on occupational therapy for children and another for bed cases round out a brief but well balanced and conservative presentation of the subject.

Chapter I, on "Significance," defines occupational therapy and outlines its field. The statement that "the creation of a pleasant mental attitude or emotion, and the stimulation of interest, is the basis for successful occupational treatment" shows the author's conception of the fundamental approach to this kind of therapy. Running through the whole book is emphasis on the great value of occupational therapy in producing satisfactory mental attitudes which are so conducive to recovery from all conditions, physical or mental.

Of special interest to nurses is the author's statement:

> It is well to entrust the administration of occupational therapy to those who have been trained for its application; that is, to occupational therapists. Just as the physician relies upon the specialized training of the nurse to take temperatures, administer medicine, watch for symptoms, and the many other duties which she is expected to fulfill: things which the physician understands and demands, but in a number of which he lacks practical skill, so must he rely upon the occupational therapist to administer the practical part of occupational therapy, because he lacks the technic of its application. The occupational therapist, therefore, has the same relation to the physician as has the nurse; that is, she is a technical assistant.

For the reason that the nurse must often work in coöperation with the occupational therapist, and, at times, even take over the application of this treatment, it is essential that she know something of its principles. I know of no better place than this book for the nurse to get her viewpoints on occupational therapy, and would recommend that the book be included in the libraries of all nurse training schools and that all of the nurses in such schools be required to read it.

The last sentence in the book is a text for all who employ occupational therapy to keep constantly in mind:

> It would indeed be unfortunate if, in our efforts to develop our patient and make him self-reliant, we train him to demand service from others.

WM. J. TIFFANY, M.D.
New York.

HOME CARE OF THE SICK. By Norma Selbert R.N., B.S., M.A. 156 pages. W. B. Saunders Company, Philadelphia. 1929. Price, $1.

MRS. SELBERT explains that her little book is intended for home-makers, students, and other nonprofessional persons who are caring for the sick in their homes. Nevertheless, she takes this opportunity to explain to these, something of what nursing means and some of the standards to apply when a graduate nurse is needed. The greater part of the book, however, is given over to the discussion of the care of the patient,

his environment and his person, to ways of making him comfortable and of treating his ills.

It is unfortunate that the author has not included more illustrations and diagrams, since often the trick of doing a thing can be caught much more quickly when the pattern lies before one. It would be helpful, too, if ways of improvising equipment were discussed and illustrated, and if the chapter on diet were more specific and included suggestions for menus. Who has not struggled with the problem of tempting a sick appetite!

While that part of the book devoted to child training is interesting, the subject does not seem to be treated completely enough to be very helpful, and might better be included in a text of another kind. There might be some question, too, as to the safety of including detailed instructions for so special a treatment as gastric lavage or eye irrigation. In most cases it would seem safer for these to be learned under the supervision of the physician or the visiting nurse.

Perhaps most helpful are the suggestions for the care and arrangement of flowers, for the personal care of the patient, for further reading, and the brief discussion of ways of securing immunity.

H. W. M., R.N.

New York.

TEXTBOOK OF SURGICAL NURSING. By Ralph Colp, M.D. and Manelva W. Keller, R.N. Second edition, revised. 514 pages. Illustrated. The Macmillan Company, New York. Price, $3.25.

IT is stated in the preface of this second edition that the entire book has been rewritten to aid graduates and undergraduates to keep pace with recent developments in surgery and surgical nursing. The reviewer finds that there has been some rearrangement of material, especially in the order in which the surgery and surgical nursing of the various systems are taken up, but little is added with the exception of a short chapter on x-ray and radium. There are, however, many new and excellent illustrations which are valuable, and some rather recent diagnostic methods are brought out throughout the book, with related surgical conditions. Many chapters, however, are almost identical with those of the first edition, possibly because they could not be improved upon.

The arrangement of both editions is somewhat illogical. Chapter I, a brief one on pathology, is followed by one on shock and hemorrhage, and Chapter III deals with postoperative complications without a previous consideration of preoperative care, which is found quite inadequately discussed in chapter XIV, entitled "Anesthesia."

No consideration is given in a general way to preoperative laboratory work as a preventive measure. For instance, hemophilia is taken up as a postoperative complication, whereas the prevention of this emergency should be stressed. Likewise, shock is well dealt with as a complication, but its prevention, which is more important, is not emphasized.

As in many texts, overlapping of subjects adds bulk and expense. Surgical dietetics should be considered in dietetic courses and variations in surgeons' orders prepared for; the theory and practice of sterilization usually comes in bacteriology and operating room experience. Over a quarter of the volume is devoted to the equipment, organization and action in the operating room and instrument passing which, while interesting, is usually determined by each individual hospital.

The subject matter of this book is excellent and unquestionably authentic as could be expected. Dr. Ralph Colp and his collaborator, Manelva Keller, are experts in their respective subjects and have shown conclusively their interdependence.

ANNE GOSMAN, R.N.

Indiana.

HISTORY OF NURSING, A PAGEANT. Compiled by Anna M. Drake, R.N. 20 pages. Published by the Ohio State Nurses' Association, Columbus, Ohio, 1929. Price, 25 cents.

THIS pageant, dedicated to the Florence Nightingale Centenary Foundation Scholarship Loan Fund of the Ohio State Nurses' Association, was "tried out" by the author on several occasions before it was put into form for publication. The outline is practical and is capable of expansion or of limitation in accordance with the capabilities of the group using it. A few pages are devoted to "Characters, Properties and Costumes."

ELEMENTARY MATERIA MEDICA. By Walter W. Krueger, Ph.B. 278 pages. Illustrated. W. B. Saunders Company, Philadelphia. 1929. Price, $1.75.

THIS textbook, of convenient size for use, containing most of the necessary subject matter for an elementary course in materia medica, will be welcomed by many students and nurses. Much of its practicability is due to its simplicity of style, its clear and carefully prepared subject matter and various aids to study.

The introduction and a most interesting review of the historical background of materia medica, including a series of splendid illustrations, make this textbook attractive and worth while.

The chapters dealing with the preparation of solutions and the necessary arithmetic are presented in such a clear and simple manner that the student should encounter little difficulty, especially if the appended laboratory exercises are carried out by the students. The questions at the end of each chapter and the well selected bibliography furnish valuable help to study.

ELSA SCHMIDT, R.N.

New York.

THE GREAT EAST GATE. By W. W. Peter, M.D. 47 pages. Illustrated. Published by The Cleanliness Institute, 45 East Seventeenth St., New York. 1929.

THE charming, format, graceful style and Oriental setting of this very modern story of the invisible pygmies, the microbes, give a wholly new slant to the oft-told tale of the battle cleanliness wages for health. Children who love fairy stories (Are there any who do not?) will be intrigued into reading to the very end. Any teacher of health may obtain a free copy from the Cleanliness Institute, with directions for ordering in larger lots.

Books Received

THE COMMON HEAD COLD AND ITS COMPLICATIONS. By Walter A. Wells, M.D. 225 pages. Illustrated. The Macmillan Company, New York. 1929. Price, $2.75.

THE NURSING MIRROR POCKET ENCYCLOPEDIA AND DIARY, 1930. 398 pages. Illustrated. Faber and Gwyer Ltd., London. 1930.

THE CARE OF THE NOSE, THROAT AND EAR. By W. Stuart-Low, F. R. C. S. Second edition. 89 pages. Illustrated. Bailliére, Tindall and Cox, London. 1929.

ROUTINES FOR MATERNITY NURSING AND BRIEFS FOR MOTHERS' CLUB TALKS. Revised. 71 pages. Illustrated. Maternity Center Association, New York. 1929. Price, 50 cents.

The "Routines" is so widely known and used that it is necessary only to state that a revised edition is available to start a landslide of orders for it.

Miscellany

Office Nursing Service for Private Physicians

AN interesting experiment, whose results may prove of considerable value to practicing physicians, is now being carried on by the Bellevue-Yorkville Health Demonstration in New York City. This plan had its inception in a letter from Health Commissioner Shirley W. Wynne to the various medical societies in New York. In this letter the Commissioner said:

"Our observations indicate that the lack of a trained office nurse frequently make it difficult, if, indeed, not impossible, for the physician in private practice to give adequate attention to this important field of medicine (preventive medicine).

"At my request the Bellevue-Yorkville Health Demonstration stands ready to finance the experiment of providing a nurse for the doctors in the district who would make use of her services in their offices on an hourly basis, primarily for the purpose of furthering their efforts in preventive medicine. During the period of the experiment there would be no charge for this service and the nurses would be responsible in no way either to the Demonstration or to the Department of Health, but in fact as well as in theory they would be employes of the private doctor."

Within a restricted area trained nurses employed by the Demonstration have accordingly been detailed to assist physicians in their office work. This nurse is helping the physician in keeping his case records, in mailing diphtheria warnings to parents and folders urging periodic medical examinations, in keeping the waiting room supplied with attractive health leaflets, tidying up the office, asisting in the examination and treatment of patients during office hours; in short, doing all that a private office nurse would ordinarily be called upon to do, but trying especially to assist the physician in developing the preventive side of his work.

It was not found feasible to conduct this work on an hourly basis, experience soon showing that it was advantageous to assign the nurse to a physician either one-half day a week or, better still, for a full day, the physician arranging his office appointments so as to make the fullest use of her services on that particular day. A single nurse is thus able to care for the work of at least six physicians. It is believed that a brief demonstration of the value of this simple plan for obtaining and utilizing the services of a nurse will lead physicians to adopt it generally and to decide thereafter to continue the service at their own expense. Present indications are that the cost to physicians for such service one full day a week will be about thirty dollars a month.—City of New York Department of Health *Weekly Bulletin*, January 11, 1930.

Mortality Statistics among Trained Nurses

THE mortality of trained nurses is very favorable. This is probably due to the fact that the group is composed mainly of young single women and, as is generally known, spinsters have an exceptionally low mortality. But even if we compare the mortality of nurses with that of spinsters, their situation is very good. Much has been written, especially in Europe, about the danger of infection as a result of nursing tuberculous patients. Some European investigators have found that as high as twelve per cent of the student nurses have been infected. There is considerable difference of opinion in the United States regarding this important question, since the issue is clouded by the fact that many institutions for the tuberculous have employed nurses who are themselves sufferers from tuberculosis. The opinion is rather generally held that nursing entails comparatively little danger because of the care and precautions which the larger and better equipped hospitals and sanatoria take to safeguard the health of their staffs. The few studies which have been made in this country indicate, however, that the incidence of tuberculosis among nurses is about a third higher than among women of the same ages in the general population.—"The Job and the Life Span," Louis Dublin, *Harper's Magazine*, January, 1930.

Official Directory

International Council of Nurses.—Sec., Christiane Reimann, 14 Quai des Eaux Vives, Geneva, Switzerland.

The American Journal of Nursing Company.—Offices, 370 Seventh Ave., New York.—Pres., Bena M. Henderson, Milwaukee Children's Hospital, Milwaukee, Wis. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Mary M. Riddle, care *American Journal of Nursing*, New York, N. Y. Elsie M. Lawler, Baltimore; Sally Johnson, Boston; Mrs. Elsbeth Vaughan, St. Louis; Elizabeth G. Fox, Washington, D. C.

Committee on the Grading of Nursing Schools.—Director, May Ayres Burgess, Ph.D., 370 Seventh Ave., New York.

The American Nurses' Association.—Headquarters, 370 Seventh Ave., New York. Pres., S. Lillian Clayton, Philadelphia General Hospital, Philadelphia, Pa. Sec., Susan C. Francis, Children's Hospital, Philadelphia, Pa. Treas., Jessie E. Catton, New England Hospital for Women and Children, Dimock St., Boston 19, Mass. Headquarters Dir., Janet M. Geister, 370 Seventh Ave., New York. Sections: **Private Duty,** Chairman, Anna C. Gladwin, 268 E. Voris St., Akron, O. **Mental Hygiene,** Chairman, Effie J. Taylor, New Haven Hospital, New Haven, Conn. **Legislation,** Chairman, Josephine E. Thurlow, Cambridge Hospital, Cambridge, Mass. **Government Nursing Service,** Chairman, Elinor D. Gregg, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C. **Relief Fund Committee,** Chairman, Carrie M. Hall, Peter Bent Brigham Hospital, Boston. **Revision Committee,** Chairman, Marie Louis, Muhlenberg Hospital, Plainfield, N. J.

The National League of Nursing Education.—Headquarters, 370 Seventh Ave., New York. Pres., Elizabeth C. Burgess, Teachers College, New York. Sec., Stella Goostray, Children's Hospital, Boston. Treas., Marian Rottman, Bellevue Hospital, New York. Ex. Sec., Nina D. Gage, 370 Seventh Ave., New York.

The National Organization for Public Health Nursing.—Pres., Mrs. Anne L. Hansen, 181 Franklin St., Buffalo, N. Y. Director, Katharine Tucker, 370 Seventh Ave., New York.

Isabel Hampton Robb Memorial Fund Committee.—Chairman, Elsie M. Lawler, Johns Hopkins Hospital, Baltimore, Md. Sec., Katharine DeWitt, 370 Seventh Ave., New York.

New England Division, American Nurses' Association.—Pres., Edith Soule, State Dept. of Health, Augusta, Maine. Sec., Elizabeth Van Patten, 35 Elm St., New Haven, Conn.

Middle Atlantic Division.—Pres., Jane E. Nash, Church Home and Infirmary, Baltimore, Md. Sec., Marion Durell, City Hosp., New York.

Mid-West Division.—Pres., Mabel Dunlap, Moline, Ill. Sec., Grace Ross, 1415 St. Antoine St., Detroit, Mich.

Northwestern Division.—Pres., Mrs. Elizabeth Soule, University of Washington, Seattle, Wash. Sec., Katherine Leahy, University of Washington, Seattle, Wash.

Southern Division.—Pres., Annie M. Beddow, Norwood Hosp., Birmingham, Ala. Sec., Bernardine Bryant, 903 First Ave., Selma, Ala.

Nursing Service, American Red Cross.—Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

U. S. Public Health Service Nurse Corps.—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau.—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau.—Supervisor of Nurses, Elinor D. Gregg, Office of the Medical Director, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C.

Department of Nursing Education, Teachers College, New York.—Director, Isabel M. Stewart, Teachers College, Columbia University.

State Associations of Nurses

Alabama.—Pres., Mattie Huston, Mobile. Sec., Linna H. Denny, 1320 N. 25th St., Birmingham. Pres. examining board, Helen MacLean, Norwood Hospital, Birmingham. Sec., Linna H. Denny, 1320 N. 25th St., Birmingham.

Arizona.—Pres., Mrs. Kathryn G. Hutchison, Tombstone. Sec., Mrs. Mildred P. Fulkerson, 735 E. Moreland St., Phoenix. Pres. examining board, Mrs. Kathryn G. Hutchison, Tombstone. Sec.-treas., Minnie C. Benson, 152 N. Church St., Tucson.

Arkansas.—Pres., Katherine Pollard, St. Vincent's Inf., Little Rock. Sec., Blanche Tomaszewska, 1004 W. 24th St., Pine Bluff. Pres. examining board, Walter G. Eberle, M.D., First National Bank Bldg., Fort Smith. Sec.-treas., Ruth Riley, Fayetteville.

California.—Pres., D. Dean Urch, Highland Hosp., Oakland. Sec., Ruth V. Wheelock, Community Hospital, Riverside. Director of headquarters, Anna C. Jammé, Room 502, 609 Sutter St., San Francisco. State League Pres., Mary M. Pickering, University of California, Berkeley. Sec., Nellie M. Porter, 819 Associated Realty Bldg., Los Angeles. Director Bureau of Registration of Nurses, Sarah G. White, State Office Bldg., Sacramento.

Colorado.—Pres., Ann Dickie Boyd, 414 14th St., Denver. Sec., Irene Murchison, Capitol Bldg., Denver. State League Pres., Ellen Perdue, 800 Central Savings Bank Bldg., Denver. Sec., Ruth Colestock, University of Colorado School of Nursing, Denver. Pres. examining board, Loretto Mulherin, Capitol Bldg., Denver. Sec., Irene Murchison, Capitol Bldg., Denver.

Connecticut.—Pres., Irene V. Muller, 28 Vineland Terrace, Hartford. Sec., Amber L. Forbush, 46 Durham Ave., Middletown. Ex. sec. and state headquarters, Margaret K. Stack, 175 Broad St., Hartford. Pres. examining board, Martha P. Wilkinson, Linden Apartment, Hartford. Sec., Mrs. Winifred A. Hart, 109 Rocton Ave., Bridgeport.

Delaware.—Pres., Evelyn Hayes, Bayard and Wawasett Ave., Wilmington. Sec., Mrs. Esther W. Petticord, 2618 Monroe St., Wilmington. Pres. examining board, Harold L. Springer, M.D., 1013 Washington St., Wilmington. Sec., Mary A. Moran, 1313 Clayton St., Wilmington.

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